AGENDA
FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
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November 17, 2009

MEMBERS
Governor Charlie Crist
Attorney General Bill McCollum
Chief Financial Officer Alex Sink
Commissioner Charles Bronson

Contact: **Monte Stevens**
(850-413-2571)

9:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for August 11, 2009 and September 15, 2009.

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Adoption of Amendments to Proposed Rule 69O-156 Part 1; Medicare Supplement Insurance

   On September 24, 2008, the National Association of Insurance Commissioners (NAIC) adopted revisions to the *NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.* The revised NAIC model regulation includes major changes to Medicare Supplement plans and benefits first approved by the NAIC in March 2007, and authorized by the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).* In addition, the model revisions contain changes required by the *Genetic Information Nondiscrimination Act of 2008 (GINA).* States must adopt the NAIC model revisions in order to continue to regulate the Medigap market. (Medicare Supplement plans are commonly referred to as Medigap.)

   (ATTACHMENT 2) **APPROVAL FOR FINAL ADOPTION**

3. Request for Approval for Adoption of Amendments to Proposed Rule 69O-137.001; Annual and Quarterly Reporting Requirements

   Section 624.424, Florida Statutes, requires every authorized insurer to file annual and quarterly statements of its financial condition with the Office of Insurance Regulation (Office). To allow uniformity in filing, the Legislature permitted the Financial Services Commission to adopt, by rule, the form for financial statements approved by the NAIC. This

rule is being amended to adopt the 2009 NAIC manuals for annual and quarterly statements and the 2009 NAIC accounting practices and procedures manual. The 2009 version is the latest version of these manuals. This will replace the current rule which adopted the 2008 version.

This rule is being amended to adopt the 2009 NAIC Quarterly and Annual Statement Instructions and also adopts the 2009 NAIC accounting practices and procedures manual.

(ATTACHMENT 3) **APPROVAL FOR FINAL ADOPTION**

4. Request for Approval for Adoption of Amendments to Proposed Rule 69O-138.001; NAIC Financial Condition Examiners Handbook Adopted

   Section 624.316, Florida Statutes, requires the Office to examine the affairs, transactions, accounts and records of authorized insurers. The law allows the Commission to adopt by rule the Financial Condition Examiners Handbook of the NAIC, in order to facilitate uniformity in examinations and reduce the frictional costs of doing business in Florida.

   This rule is being amended to adopt the 2009 NAIC Financial Condition Examiners Handbook. The current rule adopted the 2008 version.

(ATTACHMENT 4) **APPROVAL FOR FINAL ADOPTION**

5. Request for Approval for Publication of Proposed Rule 69O-170.0155; Form OIR-B1-1655 Notice of Premium Discounts for Hurricane Loss Mitigation

   Section 627.711, Florida Statutes, requires the Office to adopt a form to be used by insurers to notify applicants and policy holders of premium discounts for actions taken to mitigate the impact of hurricanes.

   This rule is being amended to adopt a revised version of existing form OIR-B1-1655, "Notice of Premium Discounts for Hurricane Loss Mitigation." Last revised in July 2007, the form is being updated to reflect changes to the My Safe Florida Home program and the experience of the Office, insurers and consumers with the form since the last revision.

(ATTACHMENT 5) **APPROVAL FOR PUBLICATION**

6. Request for Approval for Publication of Proposed Rule 69O-170.0155; Form OIR-B1-1802 Uniform Mitigation Verification Inspection

   This rule is being amended to adopt revised versions of form OIR-B1-1802, "Uniform Mitigation Verification Inspection Form." Last revised in July 2007, the form is being updated to reflect changes to the My Safe Florida Home program and the experience of the Office, insurers and consumers with the form since the last revision.

(ATTACHMENT 6) **APPROVAL FOR PUBLICATION**

7. Request by the Office and the Office of the Consumer Advocate for Approval for Publication of Proposed Rule 69O-236.001; Annual Report Card

   Section 627.0613(4), Florida Statutes, requires the Consumer Advocate's office to prepare an annual report card for each authorized personal residential property (homeowners) insurer, on a form and using a letter-grade scale developed by the Commission. The rule being proposed sets out the procedure by which the insurers would be graded and adopts the form by which the results are presented.

   (ATTACHMENT 7) **APPROVAL FOR PUBLICATION**

8. Approval of the Office of Insurance Regulation to Contract with the Proposed Vendor to Conduct the Workers' Compensation Peer Review

   Section 627.285, Florida Statutes, requires that the Financial Services Commission contract, at least once every other year, for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance in Florida.

   The National Council on Compensation Insurance (NCCI) is responsible for collecting statistical information and making workers' compensation rate filings, on behalf of Florida's insurers. By law, the contract requires the submission of a final report to the Commission, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2010.

   In order to meet this statutory requirement, the Office issued a Request for Proposal and received ten responses. The recommended winning response was submitted by American Actuarial Consulting Group, LLC. This item requests approval for the Office to enter into a contract with American Actuarial Consulting Group, LLC to perform the peer review.

   (ATTACHMENT 8) **FOR APPROVAL**

Minutes of the Financial Services Commission
August 11, 2009

Members Charlie Crist, Governor Alex Sink, Chief Financial Officer Bill McCollum, Attorney General Charles Bronson, Agriculture Commissioner	Presented by: Kevin McCarty Cabinet Meeting Room, Lower Level, The Capitol Tallahassee, Florida 32399

Item 1: Request for Approval for Adoption of the Minutes of the Financial Services Commission for June 9, 2009

Upon motion by Chief Financial Officer Alex Sink, and seconded by Attorney General Bill McCollum, the item was approved

Item 2: Request for Approval for Adoption of Proposed Rule 69O-164.040: Determining Reserve Liabilities for Preneed Life Insurance

Upon motion by Attorney General Bill McCollum, and seconded by Chief Financial Officer Alex Sink, the item was approved

Item 3: Request for Approval for Adoption of Proposed Rule 69O-163.0075,. 009,.011; Credit Life and Credit Disability

Upon motion by Chief Financial Officer Alex Sink, and seconded by Attorney General Bill McCollum, the item was approved

Minutes of the Financial Services Commission
September 15, 2009

Members Charlie Crist, Governor Alex Sink, Chief Financial Officer Bill McCollum, Attorney General Charles Bronson, Agriculture Commissioner	Presented by: Kevin McCarty Cabinet Meeting Room, Lower Level, The Capitol Tallahassee, Florida 32399

Item 1: Request for Approval for Adoption of the Minutes of the Financial Services Commission for July 28, 2009

Upon motion by Chief Financial Officer Alex Sink, and seconded by Agriculture Commissioner Charles Bronson, the item was approved

M E M O R A N D U M

DATE: September 4, 2009

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Steven H. Parton, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for September 15, 2009
Request for Final Approval to Adopt Amendments to
Rule 69O-156; Part1
Assmt. 44298

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before September 9, 2009 and to the Financial Services Commission on September 15, 2009, with a request for Final Approval to Adopt the proposed rules. A notice of the Commission Final Rule Hearing will be published in the *Florida Administrative Weekly* on August 28, 2009.

The notice of proposed rules was published June 19, 2009 in Volume 35, No. 24, of the *Weekly*. The hearing was not requested, therefore, the hearing was not held. One Notice of Change was published on August 14, 2009 in Volume 35, Number 32.

Pursuant to Section 627.674, the Financial Services Commission must adopt, by rule, minimum standards for Medicare Supplement (Medigap) policies at least as comprehensive or beneficial to persons insured under Medicare Supplement as those set forth in the NAIC Model Regulations, or as provided in federal law. On September 24, 2008, the NAIC adopted revisions to the *NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*.

A purpose of the federal rules, the NAIC model and this rule are to assure that seniors who purchase these plans are able to be wise consumers, by comparing plans that are similar in benefits (apples to apples instead of apples to oranges). Pursuant to the rules, there are a set number of benefit plans that can be offered by all insurers. Each plan has its own set of benefits, which is the same regardless of the insurer offering the plan. Plans differ by such things as deductibles and benefits payable (such as skilled nursing, necessary emergency care in foreign countries).

The revised NAIC model regulation creates different plans, each of which has been authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

The amendments also set out requirements to be followed by the insurers when an insured is offered the opportunity to exchange an existing plan for a new plan.

In addition, the model revisions contain changes required by the Genetic Information Nondiscrimination Act of 2008 (GINA).

Sections 624.308(1) 627.674(2), 627.671 through 627.675, F.S., provide rulemaking authority and laws implemented for this rule.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rules has been completed.

Bob Prentiss is the attorney handling this rule. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Steven H. Parton, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-156.003 Definitions.

For purposes of this rule:

(1) - (16) no change

(17) "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992.

(18) "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.

(19) "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

(20~~17~~) "Replacement" is any transaction wherein new Medicare supplement insurance is to be purchased and it is known to the agent, broker or insurer at the time of application that, as a part of the transaction, existing accident and health insurance has been or is to be lapsed or the benefits thereof substantially reduced.

(21~~18~~) "Secretary" means the Secretary of the United States Department of Health and Human Services.

Rulemaking ~~Specific~~ Authority 624.308(1), 627.674(2), 627.6741(5) FS. Law Implemented 624.307(1), 627.674, 627.6741 FS. History–New 1-1-81, Formerly 4-51.03, Amended 11-7-88, 9-4-89, 12-9-90, Formerly 4-51.003, Amended 1-1-92, 7-14-96, 7-26-99, 3-4-01, Formerly 4-156.003, Amended 9-15-05,_____.

69O-156.005 Policy Provisions.

(1) Except for permitted preexisting condition clauses as described in paragraphs 69O-156.006(1)(b), ~~and~~ 69O-156.007(1)(a), and 69O-156.0075(1)(a), F.A.C., of this chapter, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(2) – (4) No change

Rulemaking ~~Specific~~ Authority 624.308(1), 627.674(2) FS. Law Implemented 624.307(1), 627.674(2) FS. History–New 1-1-81, Formerly 4-51.04, Amended 9-4-89, Formerly 4-51.004, Amended 1-1-92, Formerly 4-156.005, Amended 9-15-05,_____.

69O-156.006 Minimum Benefit Standards for Pre-Standarized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to January 1, 1992.

As it relates to Pre-Standarized Medicare Supplement Benefit Plan Policies or certificates issued for delivery prior to January 1, 1992, n~~N~~o policy or certificate may be advertised, solicited, issued, delivered or issued for delivery in this State as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) Medicare supplement coverage shall provide at least, but not be limited to, the benefits provided in Section 627.674, F.S.

(b) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(c) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(d) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, ~~amount and~~ copayment, or coinsurance amounts ~~percentage factors~~. Premiums may be modified to correspond with such changes. ~~However, the changes and corresponding~~ The premium changes ~~charges~~ must be submitted to and approved by the Office pursuant to Sections 627.410, 627.411 and 627.674, F.S.

(e) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

1. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

2. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(f)1. ~~Except as authorized by the Office, a~~ An issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

2.a. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Rule ~~subparagraph~~ 69O-156.006(1)(f)4., F.A.C., the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(II) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in paragraph 69O-156.0075(2), ~~69O-156.008(5)(a) or (b)~~, F.A.C.

b. In either case, if the group policy was issued on an issue age basis, the individual Medicare supplement policy is issued at the original issue age of the terminated certificateholder, and is at the duration of the terminated certificate at the time of conversion.

3. If membership in a group is terminated, the issuer shall:

a. Offer the certificateholder such conversion opportunities as are described in subparagraph 69O-156.006(1)(f)2., F.A.C.; or

b. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

4.a. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer

coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

b. If the terminated group policy was issued on an issue age basis and the policy reserves are transferred to the new insurer, the new group certificates shall retain the original issue ages of the insureds and shall commence at the same duration as the terminated certificates.

(g) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(h) If a Medicare supplement policy eliminates an outpatient drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

(2) no change

Rulemaking ~~Specific~~ Authority 624.308(1), 627.674(2) FS. Law Implemented 624.307(1), 627.410, 627.411, 627.674, 627.6741 FS. History–New 1-1-81, Formerly 4-51.05, Amended 9-4-89, 12-9-90, Formerly 4-51.005, Amended 1-1-92, 3-4-01, 3-31-02, Formerly 4-156.006, Amended 9-15-05.

69O-156.007 Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After January 1, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.

The following standards are applicable to all 1990 standardized Medicare supplement benefit plan policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) no change

(b) no change

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, ~~amount and~~ copayment, or coinsurance amounts. ~~percentage factors.~~ Premiums may be modified to correspond with such changes. The premium changes must be submitted to and approved by the Office pursuant to Sections 627.410, ~~and~~ 627.411 and 627.674, F.S.

(d) no change

(e) no change

(f) no change

(g) no change

(h) If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized benefit plan, as described in Rule 69O-156.008, F.A.C., to a 2010 Standardized benefit plan, as described in Rule 69O-156.0085, F.A.C., the offer and subsequent exchange shall comply with the following requirements:

1. An issuer need not provide justification to the Office if the insured replaces a 1990 Standardized benefit plan policy or certificate with an issue age rated 2010 Standardized benefit plan policy or certificate at the insured's original issue age and duration. If an

insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be submitted to and approved by the Office pursuant to Sections 627.410, 627.411 and 627.674, F.S.

2. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

3. An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized benefit plan policy or certificate of the insured, but may apply preexisting condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized benefit plan policy or certificate not contained in the exchanged policy.

4. The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

(2) no change

(3) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Rule 69O-156.008, F.A.C.

(a) - (h) no change

(i) 1. Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

~~1.~~i. An annual clinical preventive medical history and physical examination that may include tests and services from Rule ~~subparagraph~~ 69O-156.007(3)(i)1.ii., ~~69O-156.007(3)(i)2.,~~ F.A.C., and patient education to address preventive health care measures.

~~2.~~ii Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

~~3~~2. Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the

service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(j) no change

(4) no change

Rulemaking ~~Specific~~ Authority 624.308, 627.674(2)(a) FS. Law Implemented 624.307(1), 627.410, 627.674, 627.6741 FS. History–New 1-1-92, Amended 7-26-99, 3-4-01, 3-31-02, Formerly 4-156.007, Amended 9-15-05.

69O-156.0075 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010.

The following standards are applicable to all 2010 Standardized Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of Rules 69O-156.006, 69O-156.007, and 69O-156.008, F.A.C.

(1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes. The premium changes must be submitted to and approved by the Office pursuant to Sections 627.410, 627.411, and 627.674, F.S.

(d) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(e) Each Medicare supplement policy shall be guaranteed renewable.

1. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

2. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

3.a. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 69O-156.0075(1)(e)5., F.A.C. , the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder:

(I) Provides for continuation of the benefits contained in the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this rule.

b. In either case, if the group policy was issued on an issue age basis, the individual Medicare supplement policy is issued at the original issue age of the terminated certificateholder, and is at the duration of the terminated certificate at the time of conversion.

4. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

a. Offer the certificateholder the conversion opportunity described in subparagraph 69O-156.0075(1)(e)3., F.A.C.; or

b. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

5.a. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

b. If the terminated group policy was issued on an issue age basis and the policy reserves are transferred to the new insurer, the new group certificates shall retain the original issue ages of the insureds and shall commence at the same duration as the terminated certificates.

6. If an individual Medicare supplement policy/certificate is issued to replace an existing issue age rated policy/certificate of the same insurer, the replacing policy/certificate shall be issued at the original issue age of the policyholder/certificateholder, and is at the duration of the terminated policy/certificate at the time of replacement.

(f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(g)1. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

2. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement

if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

3. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

4. Reinstitution of coverages as described in Subparagraphs 2. and 3.:

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(2) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(f) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(3) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 69O-156.0085, F.A.C.

(a) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(c) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(d) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to

exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

Rulemaking ~~Specific~~ Authority 624.308, 627.674(2)(a) FS. Law Implemented 624.307(1), 627.410, 627.674, 627.6741 FS. History–New _____.

69O-156.008 Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After January 1, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.

The following applies to all 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.

(1) - (4) no change

(5) (a) – (c) no change

(d) Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit (as defined in subsection ~~paragraphs~~ 69O-156.007(2)~~(a), (b), (h) and (j)~~, F.A.C., of this rule), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in paragraphs 69O-156.007(2)(a), (b), (h) and (j), F.A.C., respectively.

(e) – (l) no change

(6) - (7) no change

Rulemaking ~~Specific~~ Authority 624.308, 627.674(2) FS. Law Implemented 624.307(1),

627.674, 627.6741 FS. History–New 1-1-92, Amended 12-17-96, 7-26-99, Formerly 4-156.008, Amended 9-15-05.

69O-156.0085 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010, remain subject to the requirements of Rules 69O-156.006, 69O-156.007, and 69O-156.008, F.A.C..

(1)(a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Rule 69O-156.0075(2), F.A.C.

(b) If an issuer makes available any of the additional benefits described in Rule 69O-156.0075(3), F.A.C. , or offers standardized benefit Plans K or L as described in paragraphs 69O-156.0085(5)(h) and (i), F.A.C., then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph (1)(a) above, a policy form or certificate form containing either standardized benefit Plan C as described in paragraph 69O-156.0085(5)(c), F.A.C., or standardized benefit Plan F as described in paragraph 69O-156.0085(5)(e), F.A.C.

(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in Rules 69O-156.0085(6) and 69O-156.030, F.A.C.

(3)(a) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and as provided in Form OIR-B2-MSC2 (05/09), "Outline of Coverage, Benefit Plans, Benefit Chart of Medicare

Supplement Plans Sold on or After June 1, 2010", and shall conform to the definitions in Rule 69O-156.003, F.A.C.

(b) Form OIR-B2-MSC2 (05/09), "Outline of Coverage, Benefit Plans, Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010", is hereby adopted and incorporated by reference, and is available and may be printed from the Office's website: http://www.floir.com, by entering the form number in the search screen.

(c) Each benefit shall be structured in accordance with the format provided in Rules 69O-156.0075(2) and 69O-156.0075(3), F.A.C.; or, in the case of plans K or L, in Rules 69O-156.0085(5)(h) or 69O-156.0085(5)(i), F.A.C. and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(4) In addition to the benefit plan designations required in Rule 69O-156.0085(3), F.A.C., an issuer may use other designations to the extent permitted by law.

(5) Make-up of 2010 Standardized Benefit Plans:

(a) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Rule 69O-156.0075(2), F.A.C.

(b) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Rule 69O-156.0075(2), F.A.C., plus one hundred percent (100%) of the Medicare Part A deductible as defined in Rule 69O-156.0075(3)(a), F.A.C.

(c) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Rule 69O-156.0075(2), F.A.C., plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Rules 69O-156.0075(3)(a), (c), (d), and (f), F.A.C., respectively.

(d) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit, as defined in Rule 69O-156.0075(2), F.A.C., plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Rules 69O-156.0075(3)(a), (c), and (f), F.A.C., respectively.

(e) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Rule 69O-156.0075(2), F.A.C., plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 69O-156.0075(3)(a), (c), (d), (e),and (f), F.A.C., respectively.

(f) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph 2. below.

1. The basic (core) benefit as defined in Rule 69O-156.0075(2), F.A.C., plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 69O-156.0075(3)(a), (c), (d), (e), and (f), F.A.C., respectively.

2. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(g) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Rule 69O-156.0075(2), F.A.C., plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rules 69O-156.0075(3)(a), (c), (e), and (f), F.A.C., respectively.

(h) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

1. Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

2. Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

3. Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

4. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph 10.;

5. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph 10.;

6. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph 10.;

7. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with

federal regulations until the out-of-pocket limitation is met as described in Subparagraph 10.;

8. Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph 10.;

9. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

10. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(i) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

1. The benefits described in Rules 69O-156.0085(5)(h)1., 2., 3., and 9., F.A.C.;

2. The benefit described in Rules 69O-156.0085(5)(h)4., 5., 6., 7., and 8., F.A.C., but substituting seventy-five percent (75%) for fifty percent (50%); and

3. The benefit described in Rules 69O-156.0085(5)(h)10., F.A.C., but substituting $2000 for $4000.

(j) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Rule 69O-156.0075(2), F.A.C., plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Rules 69O-156.0075(3)(b), (c), and (f), F.A.C., respectively.

(k) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Rule 69O-156.0075(2), F.A.C., plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and

medically necessary emergency care in a foreign country as defined in Rules 69O-156.0075(3)(a), (c) and (f), F.A.C., respectively, with co-payments in the following amounts:

1. the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

2. the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(6) New or Innovative Benefits: An issuer may, with the prior approval of the Office, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Rulemaking Authority 624.308, 627.674(2) FS. Law Implemented 624.307(1), 627.674, 627.6741 FS. History–New.

69O-156.0095 Guaranteed Issue for Eligible Persons.

(1) no change

(2) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(a) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, which plan terminates or ceases to provide at least the minimum benefits as provided under a Medicare supplement plan "A" as defined in subsection 69O-156.0085(1), F.A.C., of the supplemental health benefits to the individual;

(b) – (g) no change

(3) – (6) no change

Rulemaking ~~Specific~~ Authority 624.308, 627.674(2), 627.6741(5) FS. Law Implemented 624.307(1), 627.410, 627.673, 627.674, 627.6745, 627.6746 FS. History–New 7-26-99, Amended 3-4-01, 3-31-02, Formerly 4-156.0095, Amended 9-15-05.

69O-156.011 Loss Ratio Standards and Refund or Credit of Premium.

(1) Loss Ratio Standards.

(a) – (d) no change

(e) For the purposes of this rule, the term "pre-standardized business" shall include:

1. All Medicare Supplement policies and certificates which do not comply with the benefit requirements for standardized policies as defined in Rules 69O-156.008, or 69O-156.0085, F.A.C., and

2. All policies and certificates which were marketed and issued as Medicare Supplement policies, and which have been redefined as limited benefit policies.

(f) no change

(2) Refund or Credit Calculation.

(a)1. no change

2. Forms OIR-B2-MSB-I (Rev. 06/09 ~~7/02~~), OIR-B2-MSB-G (Rev. 06/09 ~~7/02~~), and OIR-B2-MSR (Rev. 7/02) are hereby adopted and incorporated by reference. Copies of forms are available and may be printed from the Office's website: http://www.floir~~d~~fs.com/, by entering the form number in the search screen.

3. Filings shall be submitted electronically to https://iportal.fldfs.com.

(b) no change

(c) no change

(3) Annual Filing of Premium Rates.

(a)1. An issuer of Medicare supplement policies and certificates issued before or after January 1, 1992, shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Department in accordance with Sections 627.410, 627.411, and 627.6745, F.S.

2. The supporting documentation shall also demonstrate in accordance with actuarial

standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude the change in active life reserves as a component of incurred claims or earned premiums. A projected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

(b) no change

(c) no change

(4) no change

Rulemaking ~~Specific~~ Authority 624.308, 627.674(2) FS. Law Implemented 624.307(1), 627.410, 627.673, 627.674, 627.6745, 627.6746 FS. History–New 1-1-92, Amended 7-14-96, 12-17-96, 7-26-99, 3-4-01, 12-9-02, 6-19-03, Formerly 4-156.011, Amended 9-15-05.

69O-156.012 Filing and Approval of Policies and Certificates and Premium Rates.

(1) no change

(2) no change

(3)(a) – (c) no change

(d) Acceptable rate classification criteria within a form include only age, gender, area and smoker status or tobacco usage.

(4) no change

(5)(a) Except as provided in paragraph 69O-156.012(5)(b), F.A.C., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Rule 69O-156.011, F.A.C., and for all other rating purposes. The issue date of a standard Medicare supplement benefit plan is not a basis to separate experience of two or more plans of the same plan letter.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.674 FS. History–New 1-1-92, Amended 7-14-96, 3-4-01, Formerly 4-

156.012, Amended 9-15-05.

69O-156.020 Prohibition Against Use of Genetic Information and Requests for Genetic Testing.

(1) An issuer of a Medicare supplement policy or certificate;

(a) Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) on the basis of the genetic information with respect to such individual; and

(b) Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(2) Nothing in Rule 69O-156.020(1), F.A.C., shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

(3) For the purposes of this Section only "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an

individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

Rulemaking Authority 627.674 FS. Law Implemented 627.6741 FS. History–New _____.

OFFICE OF INSURANCE REGULATION
Life & Health Product Review

REPORTING FORM FOR THE CALCULATION OF BENCHMARK LOSS RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES

FOR CALENDAR YEAR ____

TYPE[1] _____ SMSBP[2] _____

FOR THE STATE OF _____ COMPANY NAME _____

NAIC GROUP CODE _____ NAIC COMPANY CODE _____

ADDRESS _____ PERSON COMPLETING EXHIBIT _____

TITLE _____ TELEPHONE NUMBER ( )-- -- _____

(A)[3]	(B)[4]	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(O)[5]
YEAR	EARNED PREMIUM	FACTOR	(B) X (C)	CUMULATIVE LOSS RATIO	(D) X (E)	FACTOR	(B) X (G)	CUMULATIVE LOSS RATIO	(H) X (I)	POLICY YEAR LOSS RATIO
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
TOTAL:			(K):		(L):		(M):		(N):	

BENCHMARK RATIO SINCE INCEPTION: (L + N)/(K + M): _____

[1] INDIVIDUAL, GROUP, INDIVIDUAL MEDICARE SELECT, OR GROUP MEDICARE SELECT ONLY 0

[2] "SMSBP" = STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN - USE "P" FOR PRE-STANDARDIZED PLANS

[3] YEAR 1 IS THE CURRENT CALENDAR YEAR - 1. YEAR 2 IS THE CURRENT CALENDAR YEAR - 2 (ETC.) (EXAMPLE: IF THE CURRENT YEAR IS 1991, THEN: YEAR 1 IS 1990; YEAR 2 IS 1989, ETC.)

[4] FOR THE CALENDAR YEAR ON THE APPROPRIATE LINE IN COLUMN (A), THE PREMIUM EARNED DURING THAT YEAR FOR POLICIES ISSUED IN THAT YEAR.

[5] THESE LOSS RATIOS ARE NOT EXPLICITLY USED IN COMPUTING THE BENCHMARK LOSS RATIOS. THEY ARE THE LOSS RATIOS, ON A POLICY YEAR BASIS, WHICH RESULT IN THE CUMULATIVE LOSS RATIOS DISPLAYED ON THIS WORKSHEET. THEY ARE SHOWN HERE FOR INFORMATIONAL PURPOSES ONLY.

[6] TO INCLUDE THE EARNED PREMIUM FOR ALL YEARS PRIOR TO AS WELL AS THE 15TH YEAR PRIOR TO THE CURRENT YEAR.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK LOSS RATIO SINCE INCEPTION FOR GROUP POLICIES

FOR CALENDAR YEAR ____

TYPE[1] _____ SMSBP[2] _____

FOR THE STATE OF _____ COMPANY NAME _____

NAIC GROUP CODE _____ NAIC COMPANY CODE _____

ADDRESS _____ PERSON COMPLETING EXHIBIT _____

TITLE _____ TELEPHONE NUMBER ( )-- -- _____

(A)[3]	(B)[4]	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(O)[5]
YEAR	EARNED PREMIUM	FACTOR	(B) X (C)	CUMULATIVE LOSS RATIO	(D) X (E)	FACTOR	(B) X (G)	CUMULATIVE LOSS RATIO	(H) X (I)	POLICY YEAR LOSS RATIO
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
TOTAL:			(K):		(L):		(M):		(N):	

BENCHMARK RATIO SINCE INCEPTION: (L + N)/(K + M): _____

[1] INDIVIDUAL, GROUP, INDIVIDUAL MEDICARE SELECT, OR GROUP MEDICARE SELECT ONLY.

[2] "SMSBP" = STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN - USE "P" FOR PRE-STANDARDIZED PLANS

[3] YEAR 1 IS THE CURRENT CALENDAR YEAR - 1. YEAR 2 IS THE CURRENT CALENDAR YEAR - 2 (ETC.) (EXAMPLE: IF THE CURRENT YEAR IS 1991, THEN: YEAR 1 IS 1990; YEAR 2 IS 1989, ETC.)

[4] FOR THE CALENDAR YEAR ON THE APPROPRIATE LINE IN COLUMN (A), THE PREMIUM EARNED DURING THAT YEAR FOR POLICIES ISSUED IN THAT YEAR.

[5] THESE LOSS RATIOS ARE NOT EXPLICITLY USED IN COMPUTING THE BENCHMARK LOSS RATIOS. THEY ARE THE LOSS RATIOS, ON A POLICY YEAR BASIS, WHICH RESULT IN THE CUMULATIVE LOSS RATIOS DISPLAYED ON THIS WORKSHEET. THEY ARE SHOWN HERE FOR INFORMATIONAL PURPOSES ONLY.

[6] TO INCLUDE THE EARNED PREMIUM FOR ALL YEARS PRIOR TO AS WELL AS THE 15TH YEAR PRIOR TO THE CURRENT YEAR.

[company name]
OUTLINE OF COVERAGE
Benefit Plans ____[insert letters of plan(s) being offered]
Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

- **Hospitalization** –Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** –Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood** –First three pints of blood each year.
- **Hospice**— Part A coinsurance

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included here. An issuer may use additional benefit plan designations on these charts pursuant to Rule 69O-156.0085(4), F.A.C.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$0	$[1068](Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0**
—Additional 365 days	$0	$0	All costs
—Beyond the additional 365 days			
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs .

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs.
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, F			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0**
Additional 365 days —Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$[135](PartB deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day $0	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0**
Additional 365 days —Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

- A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
-

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 Lifetime reserve days	All but $[534] a day	$[534] a day	$0
Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

(continued)

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
First $[135] of Medicare Approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2000] DEDUCTIBLE, ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare — Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2000] DEDUCTIBLE, ** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)♦
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts.	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[66.75] a day	Up to $[66.75] a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of Medicare co-payment/coinsurance ♦

(continued)

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[808.50] (75% of Part A deductible)	$[267] (25% of Part A deductible)♦
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[100.13] a day	Up to $[33.38] a day♦
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25%♦ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/ coinsurance	25% of co-payment/ coinsurance ♦

(continued)

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2310])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2310] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
—First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$0	$[135](PartB deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

624.308 Rules.--

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.307 General powers; duties.--

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

627.674 Minimum standards; filing requirements.--

(1) An insurance policy or subscriber contract may not be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless it meets the minimum standards adopted under this section. The minimum standards do not preclude other provisions or benefits which are not inconsistent with the minimum standards.

(2)(a) The commission must adopt rules establishing minimum standards for Medicare supplement policies that, taken together with the requirements of this part, are no less comprehensive or beneficial to persons insured or covered under Medicare supplement policies issued, delivered, or issued for delivery in this state, including certificates under group or blanket policies issued, delivered, or issued for delivery in this state, than the standards provided in 42 U.S.C. s. 1395ss, or the most recent version of the NAIC Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act adopted by the National Association of Insurance Commissioners.

(b) The rules must establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of group, blanket, franchise, and individual Medicare supplement policies and Medicare supplement subscriber contracts of dental service plans and nonprofit health care services plans. The standards may cover, but not be limited to:

1. Terms of renewability.

2. Initial and subsequent conditions of eligibility.

3. Nonduplication of coverage.

4. Probationary periods.

5. Benefit limitations, exceptions, and reductions.

6. Elimination periods.

7. Requirements for replacement coverage.

8. Recurrent conditions.

9. Definitions of terms.

10. Application forms.

(c) The commission may adopt rules that specify prohibited policies or policy provisions, not otherwise specifically authorized by statute, which in the opinion of the office are unjust, unfair, or unfairly discriminatory to the policyholder, the person insured under the policy, or the beneficiary.

(d) For policies issued on or after January 1, 1991, the commission may adopt rules to establish minimum policy standards to authorize the types of policies specified by 42 U.S.C. s. 1395ss(p)(2)(C) and any optional benefits to facilitate policy comparisons.

(3) A policy may not be filed with the office as a Medicare supplement policy unless the policy meets or exceeds the requirements of 42 U.S.C. s. 1395ss, or the most recent version of the NAIC Medicare Supplement Insurance Minimum Standards Model Act, adopted by the National Association of Insurance Commissioners.

(4) A policy filed with the office as a Medicare supplement policy must:

(a) Have a definition of "Medicare eligible expense" that is not more restrictive than health care expenses of the kinds covered by Medicare or to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as apply to Medicare claims.

(b) Provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factor. Premiums may be modified to correspond with such changes, subject to prior approval by the office.

(c) Be written in simplified language, be easily understood by purchasers, and otherwise comply with s. 627.602.

(d) Contain a prominently displayed no-loss cancellation clause enabling the applicant to return the policy within 30 days after receiving the policy, or the certificate issued thereunder, with return in full of any premium paid. The insurer must, in a timely manner, pay a refund under this paragraph directly to the individual who paid the premium.

(e) Contain a prominently displayed notice of any coordination-of-benefits clause which might in any way restrict payment under the policy.

(f)1. Be accompanied by a copy of the Medicare Supplement Buyer's Guide developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the United States Department of Health and Human Services.

2. A policy referred to in subparagraph (g)4. that does not qualify as a Medicare supplement policy under this part must also be accompanied by the buyer's guide pursuant to this paragraph.

3. Except in the case of a direct response insurer, delivery of the buyer's guide shall be made at the time of application, and acknowledgment of receipt or certification of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide upon request, but not later than at the time the policy is delivered.

(g)1. Be accompanied by an outline of coverage in the form prescribed by the National Association of Insurance Commissioners in the NAIC Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, adopted by the National Association of Insurance Commissioners on July 31, 1991, and as prescribed in s. 627.6743.

2. The outline shall be delivered to the applicant at the time application is made, and, except for the direct response policy, acknowledgment of receipt or certification of delivery of the outline of coverage shall be provided to the insurer.

3. If the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy, contract, or group certificate must accompany the policy, when it is delivered, and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

4. The following language must be printed on or attached to the first page of the outline of coverage delivered in conjunction with an individual policy of hospital confinement insurance, indemnity insurance, specified disease insurance, specified accident insurance, supplemental health insurance other than Medicare supplement insurance, or nonconventional health insurance coverage, as defined by law in this state, to a person eligible for Medicare: "This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

(5) A Medicare supplement policy may not contain benefits which duplicate benefits provided by Medicare.

627.6741 Issuance, cancellation, nonrenewal, and replacement.--

(5) The commission shall by rule prescribe standards relating to the guaranteed issue of coverage, without exclusions for preexisting conditions, for continuously covered individuals consistent with the provisions of 42 U.S.C. s. 1395ss(s)(3).

627.410 Filing, approval of forms.--

(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the office by or in behalf of the insurer which proposes to use such form and has been approved by the office. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the office for information purposes only.

(2) Every such filing must be made not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The

approval of any such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved.

(3) The office may, for cause, withdraw a previous approval. No insurer shall issue or use any form disapproved by the office, or as to which the office has withdrawn approval, after the effective date of the order of the office.

(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.

(5) This section also applies to any such form used by domestic insurers for delivery in a jurisdiction outside this state if the insurance supervisory official of such jurisdiction informs the office that such form is not subject to approval or disapproval by such official, and upon the order of the office requiring the form to be submitted to it for the purpose. The applicable same standards apply to such forms as apply to forms for domestic use.

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions which classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides to the office in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer shall no longer offer for sale the policy form or certificate form in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.

(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the office no later than 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(b) The filing required by this subsection shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules promulgated by the commission.

2. If no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(c) As used in this section, "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(d) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the office may, in addition to any

other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the office determines that the required filing is properly submitted.

(8)(a) For the purposes of subsections (6) and (7), benefits of an individual accident and health insurance policy form, including Medicare supplement policies as defined in s. 627.672, when authorized by rules adopted by the commission, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the office, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio as certified to by an actuary. The office shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the office may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.

(b) The renewal premium rates shall be deemed to be approved upon filing with the office if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:

1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.

2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.

3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the office no later than the end of such quarter. The commission shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.

4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date

of payment. Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the office has adequate time to review the report.

5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years is reached, the insurer, if directed by the office, shall withdraw the policy form for the purposes of issuing new policies.

(c) As used in this subsection:

1. "Loss ratio" means the ratio of incurred claims to earned premium.

2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio.

3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

627.411 Grounds for disapproval.--

(1) The office shall disapprove any form filed under s. 627.410, or withdraw any previous approval thereof, only if the form:

(a) Is in any respect in violation of, or does not comply with, this code.

(b) Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

(c) Has any title, heading, or other indication of its provisions which is misleading.

(d) Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

(e) Is for residential property insurance and contains provisions that are unfair or inequitable or encourage misrepresentation.

(f) Is for health insurance, and:

1. Provides benefits that are unreasonable in relation to the premium charged.

2. Contains provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation.

3. Contains provisions that apply rating practices that result in unfair discrimination pursuant to s. 626.9541(1)(g)2.

(g) Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.

(2) In determining whether the benefits are reasonable in relation to the premium charged, the office, in accordance with reasonable actuarial techniques, shall consider:

(a) Past loss experience and prospective loss experience within and without this state.

(b) Allocation of expenses.

(c) Risk and contingency margins, along with justification of such margins.

(d) Acquisition costs.

(3)(a) For health insurance coverage as described in s. 627.6561(5)(a)2., the minimum loss ratio standard of incurred claims to earned premium for the form shall be 65 percent.

(b) Incurred claims are claims occurring within a fixed period, whether or not paid during the same period, under the terms of the policy period.

1. Claims include scheduled benefit payments or services provided by a provider or through a provider network for dental, vision, disability, and similar health benefits.

2. Claims do not include state assessments, taxes, company expenses, or any expense incurred by the company for the cost of adjusting and settling a claim, including the review, qualification, oversight, management, or monitoring of a claim or incentives or compensation to providers for other than the provisions of health care services.

3. A company may at its discretion include costs that are demonstrated to reduce claims, such as fraud intervention programs or case management costs, which are identified in each filing, are demonstrated to reduce claims costs, and do not result in increasing the experience period loss ratio by more than 5 percent.

4. For scheduled claim payments, such as disability income or long-term care, the incurred claims shall be the present value of the benefit payments discounted for continuance and interest.

627.674 Minimum standards; filing requirements.--

(2)(a) The commission must adopt rules establishing minimum standards for Medicare supplement policies that, taken together with the requirements of this part, are no less comprehensive or beneficial to persons insured or covered under Medicare supplement policies issued, delivered, or issued for delivery in this state, including certificates under group or blanket policies issued, delivered, or issued for delivery in this state, than the standards provided in 42 U.S.C. s. 1395ss, or the most recent version of the NAIC Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act adopted by the National Association of Insurance Commissioners.

627.674 Minimum standards; filing requirements.–

(3) A policy may not be filed with the office as a Medicare supplement policy unless the policy meets or exceeds the requirements of 42 U.S.C. s. 1395ss, or the most recent version of the NAIC Medicare Supplement Insurance Minimum Standards Model Act, adopted by the National Association of Insurance Commissioners.

627.6746 Compliance with Omnibus Budget Reconciliation Acts.--Each entity that provides Medicare supplement policies or contracts must comply with all provisions of s. 4081 of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (OBRA) and the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508).

627.673 Designation as Medicare supplement policy; penalties for violations.--

(1) An individual, group, blanket, or franchise health insurance policy may not be delivered or issued for delivery in this state as a Medicare supplement policy unless it complies with this part.

(2) A violation of this part is punishable under s. 624.4211. In addition, the office may require insurers violating this part to cease marketing any Medicare supplement policy in this state which is related directly or indirectly to a violation of this part, or the office may require the insurer to take any action necessary to comply with this part.

(3) This part does not prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons if the policies are not marketed or held to be Medicare supplement policies or benefit plans.

(4) The loss ratio requirement applicable to Medicare supplement policies that was in effect at the time of issuance of the policy applies to policies that were issued as Medicare supplement policies and have been redefined as limited benefit policies.

627.6745 Loss ratio standards; public rate hearings.--

(1) Medicare supplement policies shall return the following to policyholders in the form of aggregate benefits under the policy, with respect to the lifetime of the policy, on the basis of earned premiums and on the basis of incurred claims experience or, if coverage is provided by a health maintenance organization based on service rather than reimbursement, incurred health care expenses, and in accordance with accepted actuarial principles and practices:

(a) At least 75 percent of the aggregate amount of premiums earned in the case of group policies.

(b) For individual policies issued or renewed prior to July 1, 1989, at least 60 percent of the aggregate amount of premiums earned and for individual policies issued on or after July 1, 1989, at least 65 percent of the aggregate amount of premiums earned. For the purposes of this section, policies issued as a result of solicitations of individuals through the mail or by mass media advertising shall be deemed to be individual policies.

(2) Each entity providing Medicare supplement policies or certificates in this state shall file annually its rates, rating schedules, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this code. The filing of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this section.

(3) For the purposes of this section, a policy form complies with the loss ratio standards if:

(a) For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for 3 years or more is greater than or equal to the applicable percentages contained in this section; and

(b) The expected losses in relation to premiums over the lifetime of the policy comply with the requirements of this section.

An expected third-year loss ratio that is greater than or equal to the applicable percentage must be demonstrated for policies or certificates in force less than 3 years. Loss ratios shall be calculated in accordance with a uniform methodology, including uniform reporting standards specified by the National Association of Insurance Commissioners pursuant to the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508).

(4) Each insurer providing Medicare supplement insurance to residents of this state shall annually submit to the office information on actual loss ratios on forms prescribed by the National Association of Insurance Commissioners pursuant to the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508).

(5) Each insurer providing Medicare supplement insurance to residents of this state shall provide a proportional refund, or a credit against future premiums of a proportional amount, based on premiums paid or based on the amount of premiums received necessary to assure that the loss ratio (net of any refunds or credits) complies with the loss ratio requirements. Such refunds or credits shall be applied to each type of policy by policy form number, and shall not apply for the first 2 years of a policy. The refund or credit shall be made to each policyholder insured under the policy as of the last day of the year involved. The refund or credit shall include interest from the end of the policy year involved until the date of the refund or credit at a rate that is not less than the average rate of interest for 13-week Treasury notes. Refunds or credits against premiums due shall be made no later than the third quarter of the succeeding policy year.

(6) Each insurer providing Medicare supplement insurance to residents of this state shall maintain and make available to interested persons a copy of each Medicare supplement policy, its most recent premium, and its loss ratios for the most recent 3-year period.

(7) The commission shall adopt a written policy statement regarding the holding of public hearings prior to approval of any premium increases for Medicare supplement insurance policies.

627.6746 Compliance with Omnibus Budget Reconciliation Acts.--Each entity that provides Medicare supplement policies or contracts must comply with all provisions of s. 4081 of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (OBRA) and the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508).

627.6742 Permitted compensation arrangements.--

(1) The commission shall adopt rules governing the permitted compensation arrangements between insurers and agents with respect to Medicare supplement policies.

627.6742 Permitted compensation arrangements.--

(1) The commission shall adopt rules governing the permitted compensation arrangements between insurers and agents with respect to Medicare supplement policies.

(2) The rules shall be based upon the format, interrelationships, and parameters relating to compensation arrangements as set forth in the NAIC Medicare Supplement Insurance Minimum Standards Model Act and Regulations adopted by the National Association of Insurance Commissioners on July 31, 1991.

627.6737 Reporting of multiple policies.--

(1) On or before March 1, every insurer or other entity providing Medicare supplement insurance coverage in this state shall report the following information for every individual resident of this state for which the insurer or entity has in force more than one Medicare supplement insurance policy or certificate:

(a) Policy and certificate number.

(b) Date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

627.671 Medicare supplement reform; short title.--Sections 627.671-627.675 may be cited as the "Florida Medicare Supplement Reform Act."

627.672 Definitions.--For the purposes of ss. 627.671-627.675:

(1) A "Medicare supplement policy" is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payments for health care costs made under Medicare, Title XVIII of the Social Security Act ("Medicare"), as presently constituted and as may later be amended, which provides reimbursement for expenses incurred for services and items for which payment may be made under Medicare but which expenses are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. The term does not include any such policy or plan of one or more labor organizations, or of the trustees of a fund established by one or more labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(2) The term "policy" includes a certificate issued or delivered in this state under a group Medicare supplement policy which has been effectuated within or outside this state.

(3) "Applicant" means:

(a) In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(b) In the case of a group Medicare supplement policy or subscriber contract, the proposed

627.673 Designation as Medicare supplement policy; penalties for violations.--

(1) An individual, group, blanket, or franchise health insurance policy may not be delivered or issued for delivery in this state as a Medicare supplement policy unless it complies with this part.

(2) A violation of this part is punishable under s. 624.4211. In addition, the office may require insurers violating this part to cease marketing any Medicare supplement policy in this state which is related directly or indirectly to a violation of this part, or the office may require the insurer to take any action necessary to comply with this part.

(3) This part does not prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons if the policies are not marketed or held to be Medicare supplement policies or benefit plans.

(4) The loss ratio requirement applicable to Medicare supplement policies that was in effect at the time of issuance of the policy applies to policies that were issued as Medicare supplement policies and have been redefined as limited benefit policies.

certificateholder.

627.673 Designation as Medicare supplement policy; penalties for violations.--

(1) An individual, group, blanket, or franchise health insurance policy may not be delivered or issued for delivery in this state as a Medicare supplement policy unless it complies with this part.

(2) A violation of this part is punishable under s. 624.4211. In addition, the office may require insurers violating this part to cease marketing any Medicare supplement policy in this state which is related directly or indirectly to a violation of this part, or the office may require the insurer to take any action necessary to comply with this part.

(3) This part does not prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons if the policies are not marketed or held to be Medicare supplement policies or benefit plans.

(4) The loss ratio requirement applicable to Medicare supplement policies that was in effect at the time of issuance of the policy applies to policies that were issued as Medicare supplement policies and have been redefined as limited benefit policies.

627.674 Minimum standards; filing requirements.--

(1) An insurance policy or subscriber contract may not be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless it meets the minimum standards adopted under this section. The minimum standards do not preclude other provisions or benefits which are not inconsistent with the minimum standards.

(2)(a) The commission must adopt rules establishing minimum standards for Medicare supplement policies that, taken together with the requirements of this part, are no less comprehensive or beneficial to persons insured or covered under Medicare supplement policies issued, delivered, or issued for delivery in this state, including certificates under group or blanket policies issued, delivered, or issued for delivery in this state, than the standards provided in 42 U.S.C. s. 1395ss, or the most recent version of the NAIC Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act adopted by the National Association of Insurance Commissioners.

(b) The rules must establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of group, blanket, franchise, and individual Medicare supplement policies and Medicare supplement subscriber

contracts of dental service plans and nonprofit health care services plans. The standards may cover, but not be limited to:

1. Terms of renewability.

2. Initial and subsequent conditions of eligibility.

3. Nonduplication of coverage.

4. Probationary periods.

5. Benefit limitations, exceptions, and reductions.

6. Elimination periods.

7. Requirements for replacement coverage.

8. Recurrent conditions.

9. Definitions of terms.

10. Application forms.

(c) The commission may adopt rules that specify prohibited policies or policy provisions, not otherwise specifically authorized by statute, which in the opinion of the office are unjust, unfair, or unfairly discriminatory to the policyholder, the person insured under the policy, or the beneficiary.

(d) For policies issued on or after January 1, 1991, the commission may adopt rules to establish minimum policy standards to authorize the types of policies specified by 42 U.S.C. s. 1395ss(p)(2)(C) and any optional benefits to facilitate policy comparisons.

(3) A policy may not be filed with the office as a Medicare supplement policy unless the policy meets or exceeds the requirements of 42 U.S.C. s. 1395ss, or the most recent version of the NAIC Medicare Supplement Insurance Minimum Standards Model Act, adopted by the National Association of Insurance Commissioners.

(4) A policy filed with the office as a Medicare supplement policy must:

(a) Have a definition of "Medicare eligible expense" that is not more restrictive than health care expenses of the kinds covered by Medicare or to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as apply to Medicare claims.

(b) Provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factor. Premiums may be modified to correspond with such changes, subject to prior approval by the office.

(c) Be written in simplified language, be easily understood by purchasers, and otherwise comply with s. 627.602.

(d) Contain a prominently displayed no-loss cancellation clause enabling the applicant to return the policy within 30 days after receiving the policy, or the certificate issued thereunder, with return in full of any premium paid. The insurer must, in a timely manner, pay a refund under this paragraph directly to the individual who paid the premium.

(e) Contain a prominently displayed notice of any coordination-of-benefits clause which might in any way restrict payment under the policy.

(f)1. Be accompanied by a copy of the Medicare Supplement Buyer's Guide developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the United States Department of Health and Human Services.

2. A policy referred to in subparagraph (g)4. that does not qualify as a Medicare supplement policy under this part must also be accompanied by the buyer's guide pursuant to this paragraph.

3. Except in the case of a direct response insurer, delivery of the buyer's guide shall be made at the time of application, and acknowledgment of receipt or certification of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers shall deliver the buyer's guide upon request, but not later than at the time the policy is delivered.

(g)1. Be accompanied by an outline of coverage in the form prescribed by the National Association of Insurance Commissioners in the NAIC Model Regulation To Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, adopted by the National Association of Insurance Commissioners on July 31, 1991, and as prescribed in s. 627.6743.

2. The outline shall be delivered to the applicant at the time application is made, and, except for the direct response policy, acknowledgment of receipt or certification of delivery of the outline of coverage shall be provided to the insurer.

3. If the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy, contract, or group certificate must accompany the policy, when it is delivered, and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

4. The following language must be printed on or attached to the first page of the outline of coverage delivered in conjunction with an individual policy of hospital confinement insurance, indemnity insurance, specified disease insurance, specified accident insurance, supplemental health insurance other than Medicare supplement insurance, or nonconventional health insurance coverage, as defined by law in this state, to a person eligible for Medicare: "This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

(5) A Medicare supplement policy may not contain benefits which duplicate benefits provided by Medicare.

627.675 Mandated coverages inapplicable to Medicare supplement policies unless specifically made applicable.--No coverage which is required by a law of this state enacted on or after the effective date of this act to be included in group, individual, blanket, or franchise disability policies need be included in any Medicare supplement policy unless inclusion thereof is specifically made applicable to Medicare supplement policies by the terms of such law.

626.9611 Rules.--

(1) The department or commission may, in accordance with chapter 120, adopt reasonable rules as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by s. 626.9541 or s. 626.9551, but the rules shall not enlarge upon or extend the provisions of ss. 626.9541 and 626.9551.

(2) The department and the commission shall, in accordance with chapter 120, adopt rules to protect members of the United States Armed Forces from dishonest or predatory insurance sales practices by insurers and insurance agents. The rules shall identify specific false, misleading, deceptive, or unfair methods of competition, acts, or practices which are prohibited by s. 626.9541 or s. 626.9551. The rules shall be based upon model rules or model laws adopted by the National Association of Insurance Commissioners which identify certain insurance practices involving the solicitation or sale of insurance and annuities to members of the United States Armed Forces which are false, misleading, deceptive, or unfair.

626.830 Purpose of license.--

(1) The purpose of a license issued under this code to a health agent is to authorize and enable the licensee actively and in good faith to engage in the insurance business as such an agent with respect to the general public and to facilitate the public supervision of such activities in the public interest, and not for the purpose of enabling the licensee to receive an unlawful rebate of premium in the form of commission or other compensation as an agent or enabling the licensee to receive commissions or other compensation based upon insurance solicited or procured by or through the licensee upon his or her own interests or upon those of other persons with whom he or she is closely associated in capacities other than as an insurance agent.

(2) The department shall not grant, renew, continue, or permit to exist any license or appointment as a health agent as to any applicant therefor or licensee or appointee thereunder if it finds that the license or appointment has been or is being or will be used by the applicant, licensee, or appointee not for the purpose of holding himself or herself out to the general public as a health agent, but principally for the purpose of soliciting, negotiating, handling or procuring "controlled business," that is, health insurance covering himself or herself or family members; the officers, directors, stockholders, partners, employees, or debtors of a partnership, association, or corporation of which he or she or a family member is an officer, director, stockholder, partner, or employee; or members of an association of which he or she is a director, officer, or employee.

(3) A violation of this section shall be deemed to exist or be probable if the department finds that during a 12-month period the premium writings represented by such controlled business insurance contracts signed, countersigned, issued, or sold by the licensee have been, or in the case of an applicant for appointment, probably will be under circumstances found by the department to exist, in excess of premium writings during the same period by the appointee or proposed appointee as represented by health insurance contracts to the general public other than the classes of persons above classified as controlled business.

(4) This section shall not be deemed to prohibit the licensing and appointing of any person employed by or associated with a lending or financing institution, with respect to insurance only, under credit life or disability insurance policies of borrowers from such institution or creditor.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.--

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.--The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(a) *Misrepresentations and false advertising of insurance policies.*--Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.

2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.

3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.

4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.

5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.

6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.

7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.

8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.

9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

(b) *False information and advertising generally.*--Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:

1. In a newspaper, magazine, or other publication,

2. In the form of a notice, circular, pamphlet, letter, or poster,

3. Over any radio or television station, or

4. In any other way,

an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.

(e) *False statements and entries.*--

1. Knowingly:

a. Filing with any supervisory or other public official,

b. Making, publishing, disseminating, circulating,

c. Delivering to any person,

d. Placing before the public,

e. Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public,

any false material statement.

2. Knowingly making any false entry of a material fact in any book, report, or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.

(k) *Misrepresentation in insurance applications.*--

1. Knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.

(l) *Twisting.*--Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer.

626.9641 Policyholders, bill of rights.--

(1) The principles expressed in the following statements shall serve as standards to be followed by the department, commission, and office in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules:

(a) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.

(b) Policyholders shall have the right to obtain comprehensive coverage.

(c) Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.

(d) Policyholders shall have a right to an insurance company that is financially stable.

(e) Policyholders shall have the right to be serviced by a competent, honest insurance agent or broker.

(f) Policyholders shall have the right to a readable policy.

(g) Policyholders shall have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses.

(h) Policyholders shall have the right to a balanced and positive regulation by the department, commission, and office.

M E M O R A N D U M

DATE: September 16, 2009

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Steven H. Parton, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for October 13, 2009
Request for Final Approval to Adopt Amendments to
Rule 69O-137.001; Annual and Quarterly Reporting Requirements
Assignment 44295

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before October 7, 2009 and to the Financial Services Commission on October 13, 2009, with a request for Final Approval to Adopt the proposed rules. A notice of the Commission Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 25, 2009.

The notice of proposed rules was published August 14, 2009, in Volume 35, No. 32, of the *Weekly*. The hearing was not requested, therefore, the hearing was not held. One Notice of Change was made adding the manuals incorporated in Volume 35, number 34, published August 28, 2009.

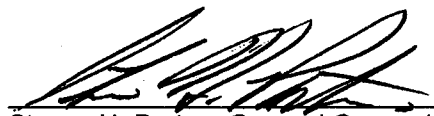
Section 624.424, Florida Statutes, requires every authorized insurer to file annual and quarterly statements of its financial condition with the Office of Insurance Regulation (Office). To allow uniformity in filing, the Legislature permitted the Financial Services Commission to adopt, by rule, the form for financial statements approved by the NAIC. This rule is being amended to adopt the 2009 NAIC manuals for annual and quarterly statements and the 2009 NAIC accounting practices and procedures manual. The 2009 version is the latest version of these manuals. The will replace the current rule which adopted the 2008 version.

Sections 624.308(1) and 624.424(1), F.S., provide rulemaking authority and laws implemented for this rule.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rules has been completed.

Laura Parsons is handling this rule. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:



Steven H. Parton, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-137.001 Annual and Quarterly Reporting Requirements.

(1) through (3) – no change

(4) Manuals Adopted

(a) Annual statements shall be prepared in accordance with the following manuals, which are hereby adopted and incorporated by reference:

1. The NAIC's Annual Statement Instructions, Property and Casualty, 2009~~2008~~;

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 2009~~2008~~;

3. The NAIC's Annual Statement Instructions, Health, 2009~~2008~~; and

4. The NAIC's Quarterly and Annual Statement Instructions, Title, 2009~~2008~~

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2009 ~~2008~~.

(b) Quarterly statements shall be prepared in accordance with the following manuals, which are hereby adopted and incorporated by reference:

1. The NAIC's Quarterly Statement Instructions, Property and Casualty, 2009 ~~2008~~;

2. The NAIC's Quarterly Statement Instructions, Life, Accident and Health, 2009 ~~2008~~;

3. The NAIC's Quarterly Statement Instructions, Health, 2009 ~~2008~~;

4. The NAIC's Quarterly Statement Instructions, Title, 2009 ~~2008~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2009 ~~2008~~.

(c) – no change

Rulemaking ~~Specific~~ Authority: 624.308(1), 624.424(1), F.S. Law implemented: 624.424(1), F.S. History–New 3-31-92, Amended 8-24-93, 4-9-95, 4-9-97, 4-4-99, 11-30-99, 2-11-01, 4-5-01, 12-4-01, 12-25-01, 8-18-02, 7-27-03, Formerly 4-137.001, Amended 1-6-05, 9-15-05, 1-25-07, _____.

624.308 Rules.--

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.424 Annual statement and other information.--

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office or such organization as the office may designate all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, under criteria established by rule of the commission. In adopting the rule, the commission must consider any criteria established by the National Association of Insurance Commissioners. The office may require semiannual updates of the annual statement of opinion as to a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance or title insurance.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

M E M O R A N D U M

DATE: September 16, 2009

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Steven H. Parton, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for October 13, 2009
Request for Final Approval to Adopt Amendments to
Rule 69O-138.001; NAIC Financial Examiners Handbook Adopted
Assignment 44296

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before October 7, 2009 and to the Financial Services Commission on October 13, 2009, with a request for Final Approval to Adopt the proposed rules. A notice of the Commission Final Rule Hearing will be published in the *Florida Administrative Weekly* on September 25, 2009.

The notice of proposed rules was published August 14, 2009 in Volume 35, No. 32, of the *Weekly*. The hearing was not requested, therefore, the hearing was not held. No Notice of Change was made.

Section 624.316, Florida Statutes, requires the Office to examine the affairs, transactions, accounts and records of authorized insurers. The law allows the Commission to adopt by rule the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners (NAIC), in order to facilitate uniformity in examinations and reduce the frictional costs of doing business in Florida. This rule is being amended to adopt the 2009 NAIC Financial Condition Examiners Handbook. The current rule adopted the 2008 version.

Sections 624.308(1) and 624.316(1)(c), F.S., provide rulemaking authority and laws implemented for this rule.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rules has been completed.

Laura Parsons is handling this rule. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Steven H. Parton, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.

(1)(a) No change.

(b) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 20092~~2008~~ is hereby adopted and incorporated by reference.

(2) – (3) No change.

Rulemaking ~~Specific~~ Authority 624.308(1), 624.316(1)(c) FS. Law Implemented 624.316(1)(c) FS. History–New 3-30-92, Amended 4-9-97, 4-4-99, 11-30-99, 2-11-01, 12-25-01, 8-18-02, 7-27-03, Formerly 4-138.001, Amended 1-6-05, 9-15-05, 1-25-07,_____.

624.308 Rules.--

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.316 Examination of insurers.–

(1)(c) The office shall examine each insurer according to accounting procedures designed to fulfill the requirements of generally accepted insurance accounting principles and practices and good internal control and in keeping with generally accepted accounting forms, accounts, records, methods, and practices relating to insurers. To facilitate uniformity in examinations, the commission may adopt, by rule, the Market Conduct Examiners Handbook and the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners, 2002, and may adopt subsequent amendments thereto, if the examination methodology remains substantially consistent.

M E M O R A N D U M

DATE: September 22, 2009

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Steven H. Parton, General Counsel SHP

FROM: Dennis Threadgill DT
Bob Prentiss BP

SUBJECT: Cabinet Agenda for October 13,2009
Request for Approval to Publish Amendments to
Rule 69O-170.0155,Form OIR-B1-1655
Assmt. # 44282

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before October 7, 2009 and to the Financial Services Commission on October 13, 2009, with a request to approve for publication the proposed rules.

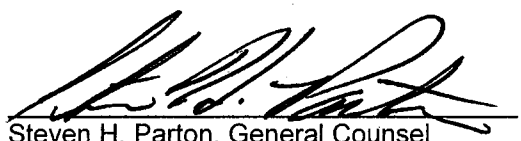
Section 627.711 requires the Office of Insurance Regulation to adopt a form to be used by insurers to notify applicants and policy holders of premium discounts for actions taken to mitigate the impact of hurricanes.

This rule is being amended to adopt a revised version of Office of Insurance Regulation form OIR-B1-1655, "Notice of Premium Discounts for Hurricane Loss Mitigation. Form OIR-B1-1655 is being revised based on changes to the My Safe Florida Home program and the experience of the Office of Insurance Regulation, insurers and policyholders with the forms since its last revisions in July 2007.

Sections 624.308, 627.711,215.5586, F.S., provide specific authority and laws implemented for this rule. DJW

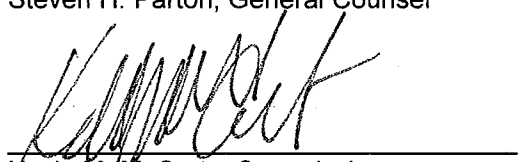
Stacy Wilhite is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the specific statutory authority and law implemented.

Approved for signature:



Steven H. Parton, General Counsel

Approved for submission to Financial Services Commission:



Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-170.0155 Forms

The following forms are hereby adopted and incorporated by reference:

(1)(a) – (j) No change.

(k) OIR-B1-1655, "Notice of Premium Discounts for Hurricane Loss Mitigation," (Rev. ~~7/07~~ 09/09).

(1)(l) – (n) No change.

(2)(a) – (b) No change.

Rulemaking ~~Specific~~ Authority: 624.308(1), 627.711, 627.736 F.S. Law Implemented: 215.5586, 624.307(1), 624.424, 627.062, 627.0629, 627.0645, 627.711, 627.736 F.S. History–New 6-19-03, Formerly 4-170.0155, Amended 2-23-06, 12-26-06, 6-12-07, 7-17-07, 9-5-07, 3-13-08, _____.

Notice of Premium Discounts for Hurricane Loss Mitigation

*** Important Information ***

About Your Personal Residential Insurance Policy

Dear Homeowner,

Hurricanes have caused tens of billions of dollars in insured damages and predictions of more catastrophic hurricanes making landfall in Florida have triggered increases in insurance premiums to cover potential future losses. Enclosed is information regarding wind loss mitigation that will make your home more resistant to wind and help protect your family during a catastrophic event. In addition to reducing your hurricane wind premium by installing mitigation features, you may also reduce the likelihood of out of pocket expenses, such as your hurricane deductible, you may otherwise incur after a catastrophic event.

What factors are considered in establishing my premium?

Your location: The closer a home is to the coast, the more vulnerable it is to damage caused by hurricane winds. This makes the hurricane-wind premium higher than for similar homes in other areas of the state.

Your policy: Your insurance policy is divided into two premiums: one for damage caused by hurricane force winds (hurricane-wind) and one for all other damage (all perils), such as fire.

Your deductible: Under the law, you are allowed to choose a $500, 2%, 5% or 10% deductible, depending on the actual value of your home. The larger your deductible, the lower your hurricane-wind premium. However, if you select a higher deductible your out-of-pocket expenses in the event of a hurricane claim will be higher.

Improvements to your home: The state requires insurance companies to offer discounts for protecting your home against damage caused by hurricane winds. Securing your roof so it doesn't blow off and protecting your windows from flying debris are the two most cost effective measures you can take to safeguard your home and reduce your hurricane –wind premium. Discounts apply only to the hurricane-wind portion of your policy.

The costs of the improvement projects vary. Homeowners should contact a licensed contractor for an estimate. You can find a Certified Contractor in your area by visiting the Florida Department of Business and Professional Regulation online at www.myfloridalicense.com.

Your maximum discount: Discounts are not calculated cumulatively. The total discount is not the sum of the individual discounts. Instead, when one discount is applied, other discounts are reduced until you reach your maximum discount of XX%.

How can I take advantage of the discounts?

Most homeowners will need a building code inspector certified under Section 468.607, Florida Statutes, or a general, building, or residential contractor licensed under Section 489.111, Florida Statutes, or a professional engineer licensed under Section 471.015, Florida Statutes, who has passed the appropriate equivalency test of the Building Code training program as required by Section 553.841, Florida Statutes, or a professional architect licensed under Section 481.213, Florida Statutes to inspect the home to identify potential mitigation measures and legally verify improvements. There may be other inspection professionals available. For a listing of individuals and/or inspection companies meeting these qualifications contact your insurance agent or insurance company.

The following is an example of how much you can reduce your insurance premium if you have mitigating features on your home. The example is based on your hurricane-wind premium* of _____which is part of your total annual premium of _____. Remember, the discounts shown only apply to the hurricane-wind portion of the premium and the discounts for the construction techniques and features listed below are not cumulative.

*** Wind mitigation credits apply to that portion of your premium that covers the peril of wind, whether or not a hurricane exists.**

Homes built prior to the 2001 building code

Description of Feature	Estimated* Premium Discount Percent	Estimated* Annual Premium ($) is **Reduced** by:
Roof Covering (i.e., shingles or tiles) • Meets the Florida Building Code. • Reinforced Concrete Roof Deck. (If this feature is installed on your home you most likely will not qualify for any other discount.)		
How Your Roof is Attached • Using a 2" nail spaced at 6" from the edge of the plywood and 12" in the field of the plywood. • Using a 2 1/2" nail spaced at 6" from the edge of the plywood and 12" in the field of the plywood. • Using a 2 1/2" nail spaced at 6" from the edge of the plywood and 6" in the field of the plywood.		

Roof-to-Wall Connection • Using "Toe Nails" – defined as 3 nails are driven at an angle through the rafter and into the top roof. • Using Clips - defined as pieces of metal that are nailed into the side of the rafter/truss and into the side of the top plate or wall stud. • Using Single Wraps – a single strap that is attached to the side and/or bottom of the top plate and are nailed to the rafter/truss. • Using Double Wraps - straps are attached to the side and/or bottom of the top plate and are nailed to the rafter/truss.		
Roof Shape • Hip Roof – defined as your roof sloping down to meet all your outside walls (like a pyramid). • Other.		
Secondary Water Resistance (SWR) • SWR – defined as a layer of protection between the shingles and the plywood underneath that protects the building if the shingles blow off. • No SWR.		
Shutters • None. • Intermediate Type —shutters that are strong enough to meet half the old Miami-Dade building code standards. • Hurricane Protection Type -- shutters that are strong enough to meet the current Miami-Dade building code standards.		

* Estimate is based on information currently on file and the actual amount may vary.

Homes built under the 2001 building code or later

Description of Feature	Estimated* Premium Discount Percent	Estimated* Annual Premium ($) is **Reduced** by:
Homes built under the 2001 Florida Building Code or later edition (also including the 1994 South Florida Building Code for homes in Miami-Dade and Broward Counties) are eligible for a minimum 68% discount on the hurricane-wind portion of your premium. You may be eligible for greater discount if other mitigation features are installed on your home.		
Shutters • None. • Intermediate Type —shutters that are strong enough to meet half the old Miami-Dade building code standards. • Hurricane Protection Type -- shutters that are strong enough to meet the current Miami-Dade building code standards.		
Roof Shape • Hip Roof – defined as your roof sloping down to meet all your outside walls (like a pyramid). • Other.		

* Estimate is based on information currently on file and the actual amount may vary.

Alternately and regardless of the year of construction, if you meet the minimum fixture and construction requirements of the 2001 Florida Building Code you have the option to reduce your hurricane-wind deductible from _____ to _____.

If you have further questions about the construction techniques and features or other construction techniques and features that could result in a discount, please contact your insurance agent or the insurance company at _____.

624.308 Rules.--

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.--

(1) Using a form prescribed by the Office of Insurance Regulation, the insurer shall clearly notify the applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability and the range of each premium discount, credit, other rate differential, or reduction in deductibles, and combinations of discounts, credits, rate differentials, or reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed or implemented. The prescribed form shall describe generally what actions the policyholders may be able to take to reduce their windstorm premium. The prescribed form and a list of such ranges approved by the office for each insurer licensed in the state and providing such discounts, credits, other rate differentials, or reductions in deductibles for properties described in this subsection shall be available for electronic viewing and download from the Department of Financial Services' or the Office of Insurance Regulation's Internet website. The Financial Services Commission may adopt rules to implement this subsection.

(2) By July 1, 2007, the Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form certified by the Department of Financial Services or signed by:

(a) A hurricane mitigation inspector employed by an approved My Safe Florida Home wind certification entity;

(b) A building code inspector certified under s. 468.607;

(c) A general or residential contractor licensed under s. 489.111;

(d) A professional engineer licensed under s. 471.015 who has passed the appropriate equivalency test of the Building Code Training Program as required by s. 553.841; or

(e) A professional architect licensed under s. 481.213.

(f) Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form.

(3) An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

627.736 Required personal injury protection benefits; exclusions; priority; claims.--

(1) REQUIRED BENEFITS.--Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(e), to a limit of $10,000 for loss sustained by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*--Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. However, the medical benefits shall provide reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided by any of the following persons or entities:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.

3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.

4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under ss. 400.990-400.995 that is:

a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

b. A health care clinic that:

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) *Disability benefits.*--Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision shall be paid not less than every 2 weeks.

(c) *Death benefits.*--Death benefits equal to the lesser of $5,000 or the remainder of unused personal injury protection benefits per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

(2) AUTHORIZED EXCLUSIONS.--Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

1. Causing injury to himself or herself intentionally; or

2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.--No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.

(4) BENEFITS; WHEN DUE.--Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. When an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this shall not limit the introduction of evidence at trial; and the insurer shall include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. However, notwithstanding the fact that written notice has been furnished to the insurer, any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. This paragraph does not preclude or limit

the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion by the insurer may be made at any time, including after payment of the claim or after the 30-day time period for payment set forth in this paragraph.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002(9), or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of a claim from a physician or dentist who provided emergency services and care or who provided hospital inpatient care may then be used by the insurer to pay other claims. The time periods specified in paragraph (b) for required payment of personal injury protection benefits shall be tolled for the period of time that an insurer is required by this paragraph to hold payment of a claim that is not from a physician or dentist who provided emergency services and care or who provided hospital inpatient care to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(d) All overdue payments shall bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the year in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest shall be due at the time payment of the overdue claim is made.

(e) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle, provided the injured person is not himself or herself:

a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner or owners of such a motor vehicle.

(f) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(h) Benefits shall not be due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or if it is established in a court of competent jurisdiction. Any insurance fraud shall void all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid prior to the discovery of the insured person's insurance fraud shall be recoverable by the insurer from the person who committed insurance fraud in their entirety. The prevailing party is entitled to its costs and attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

(a)1. Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

2. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002(9) provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

3. For purposes of subparagraph 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered, except that it may not be less than the allowable amount under the participating physicians schedule [1]of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

4. Subparagraph 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

5. If an insurer limits payment as authorized by subparagraph 2., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, provided that before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make a reasonable good faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The initial list shall be adopted by January 1, 2004, and shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list of invalid diagnostic tests shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and shall not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for any invalid diagnostic test as determined by the Department of Health.

(c)1. With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider shall not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

2. If, however, the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

3. For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph; and the insurer shall not be considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Health Care Finance Administration.

4. Each notice of insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.--Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. No statement of medical services may include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer shall not be considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. This disclosure and acknowledgment form is not required for services billed by a provider for emergency services as defined in s. 395.002, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form that shall be used to fulfill the requirements of this paragraph, effective 90 days after such form is adopted and becomes final. The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form of its own which otherwise complies with the requirements of this paragraph.

8. As used in this paragraph, "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, that is consistent with the services being rendered to the patient as claimed. The requirements of this subparagraph for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, then the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.--

(a) Every employer shall, if a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, furnish forthwith, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." No cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against any physician, hospital, clinic, or other medical institution complying with the provisions of this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount which is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. Any insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of any dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice

to all persons having an interest, and it shall specify the time, place, manner, conditions, and scope of the discovery. Such court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under the provisions of this section, and shall pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.--

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, then such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to

the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.--With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 shall apply, except as provided in subsections (10) and (15).

(9) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

(10) DEMAND LETTER.--

(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice required shall state that it is a "demand letter under s. 627.736(10)" and shall state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.

2. The claim number or policy number upon which such claim was originally submitted to the insurer.

3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if so requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices pursuant to this subsection shall be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection in the event no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty shall not be payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for a period of 30 business days by the mailing of the notice required by this subsection.

(f) Any insurer making a general business practice of not paying valid claims until receipt of the notice required by this subsection is engaging in an unfair trade practice under the insurance code.

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.--

(a) If an insurer fails to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice, the insurer is engaging in a prohibited unfair or deceptive practice that is subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 with respect thereto.

(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

(12) CIVIL ACTION FOR INSURANCE FRAUD.--An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) MINIMUM BENEFIT COVERAGE.--If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

(14) FRAUD ADVISORY NOTICE.--Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, advising that:

(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.

(15) ALL CLAIMS BROUGHT IN A SINGLE ACTION.--In any civil action to recover personal injury protection benefits brought by a claimant pursuant to this section against an insurer, all claims related to the same health care provider for the same injured person shall be brought in one action, unless good cause is shown why such claims should be brought separately. If the court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney's fees to the claimant.

(16) SECURE ELECTRONIC DATA TRANSFER.--If all parties mutually and expressly agree, a notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

215.5586 My Safe Florida Home Program.--There is established within the Department of Financial Services the My Safe Florida Home Program. The department shall provide fiscal accountability, contract management, and strategic leadership for the program, consistent with this section. This section does not create an entitlement for property owners or obligate

the state in any way to fund the inspection or retrofitting of residential property in this state. Implementation of this program is subject to annual legislative appropriations. It is the intent of the Legislature that the My Safe Florida Home Program provide inspections for at least 400,000 site-built, single-family, residential properties and provide grants to at least 35,000 applicants before June 30, 2009. The program shall develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that shall include the following:

(1) HURRICANE MITIGATION INSPECTIONS.--

(a) Free home-retrofit inspections of site-built, single-family, residential property shall be offered throughout the state to determine what mitigation measures are needed, what insurance premium discounts may be available, and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. The Department of Financial Services shall contract with wind certification entities to provide free hurricane mitigation inspections. The inspections provided to homeowners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies recommended improvements a homeowner may take to mitigate hurricane damage.

2. A range of cost estimates regarding the recommended mitigation improvements.

3. Insurer-specific information regarding premium discounts correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.

4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities. As soon as practical, the rating scale must be the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865.

(b) To qualify for selection by the department as a wind certification entity to provide hurricane mitigation inspections, the entity shall, at a minimum, meet the following requirements:

1. Use hurricane mitigation inspectors who:

a. Are certified as a building inspector under s. 468.607;

b. Are licensed as a general or residential contractor under s. 489.111;

c. Are licensed as a professional engineer under s. 471.015 and who have passed the appropriate equivalency test of the Building Code Training Program as required by s. 553.841;

d. Are licensed as a professional architect under s. 481.213; or

e. Have at least 2 years of experience in residential construction or residential building inspection and have received specialized training in hurricane mitigation procedures. Such training may be provided by a class offered online or in person.

2. Use hurricane mitigation inspectors who also:

a. Have undergone drug testing and level 2 background checks pursuant to s. 435.04. The department may conduct criminal record checks of inspectors used by wind certification entities. Inspectors must submit a set of the fingerprints to the department for state and national criminal history checks and must pay the fingerprint processing fee set forth in s. 624.501. The fingerprints shall be sent by the department to the Department of Law Enforcement and forwarded to the Federal Bureau of Investigation for processing. The results shall be returned to the department for screening. The fingerprints shall be taken by a law enforcement agency, designated examination center, or other department-approved entity; and

b. Have been certified, in a manner satisfactory to the department, to conduct the inspections.

3. Provide a quality assurance program including a reinspection component.

(c) The department shall implement a quality assurance program that includes a statistically valid number of reinspections.

(d) An application for an inspection must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application for that home.

(e) The owner of a site-built, single-family, residential property may apply for and receive an inspection without also applying for a grant pursuant to subsection (2) and without meeting the requirements of paragraph (2)(a).

(2) MITIGATION GRANTS.--Financial grants shall be used to encourage single-family, site-built, owner-occupied, residential property owners to retrofit their properties to make them less vulnerable to hurricane damage.

(a) To be eligible for a grant for persons who have obtained a completed inspection after May 1, 2007, a residential property must:

1. Have been granted a homestead exemption under chapter 196.

2. Be a dwelling with an insured value of $300,000 or less. Homeowners who are low-income persons, as defined in s. 420.0004(10), are exempt from this requirement.

3. Have undergone an acceptable hurricane mitigation inspection.

4. Be located in the "wind-borne debris region" as that term is defined in s. 1609.2, International Building Code (2006).

5. Be a home for which the building permit application for initial construction was made before March 1, 2002.

An application for a grant must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application and must have attached documents demonstrating the applicant meets the requirements of this paragraph.

(b) All grants must be matched on a dollar-for-dollar basis for a total of $10,000 for the actual cost of the mitigation project with the state's contribution not to exceed $5,000.

(c) The program shall create a process in which contractors agree to participate and homeowners select from a list of participating contractors. All mitigation must be based upon the securing of all required local permits and inspections and must be performed by properly licensed contractors. Mitigation projects are subject to random reinspection of up to at least 5 percent of all projects. Hurricane mitigation inspectors qualifying for the program may also participate as mitigation contractors as long as the inspectors meet the department's qualifications and certification requirements for mitigation contractors.

(d) Matching fund grants shall also be made available to local governments and nonprofit entities for projects that will reduce hurricane damage to single-family, site-built, owner-occupied, residential property. The department shall liberally construe those requirements in favor of availing the state of the opportunity to leverage funding for the My Safe Florida Home Program with other sources of funding.

(e) When recommended by a hurricane mitigation inspection, grants may be used for the following improvements only:

1. Opening protection.

2. Exterior doors, including garage doors.

3. Brace gable ends.

The department may require that improvements be made to all openings, including exterior doors and garage doors, as a condition of reimbursing a homeowner approved for a grant.

(f) Grants may be used on a previously inspected existing structure or on a rebuild. A rebuild is defined as a site-built, single-family dwelling under construction to replace a home that was destroyed or significantly damaged by a hurricane and deemed unlivable by a regulatory authority. The homeowner must be a low-income homeowner as defined in paragraph (g), must have had a homestead exemption for that home prior to the hurricane, and must be intending to rebuild the home as that homeowner's homestead.

(g) Low-income homeowners, as defined in s. 420.0004(10), who otherwise meet the requirements of paragraphs (a), (c), (e), and (f) are eligible for a grant of up to $5,000 and are not required to provide a matching amount to receive the grant. Additionally, for low-income homeowners, grant funding may be used for repair to existing structures leading to any of the mitigation improvements provided in paragraph (e), limited to 20 percent of the grant value. The program may accept a certification directly from a low-income homeowner that the homeowner meets the requirements of s. 420.0004(10) if the homeowner provides such certification in a signed or electronically verified statement made under penalty of perjury.

(h) The department shall establish objective, reasonable criteria for prioritizing grant applications, consistent with the requirements of this section.

(i) The department shall develop a process that ensures the most efficient means to collect and verify grant applications to determine eligibility and may direct hurricane mitigation inspectors to collect and verify grant application information or use the Internet or other electronic means to collect information and determine eligibility.

(3) EDUCATION AND CONSUMER AWARENESS.--The department may undertake a statewide multimedia public outreach and advertising campaign to inform consumers of the availability and benefits of hurricane inspections and of the safety and financial benefits of residential

hurricane damage mitigation. The department may seek out and use local, state, federal, and private funds to support the campaign.

(4) ADVISORY COUNCIL.--There is created an advisory council to provide advice and assistance to the department regarding administration of the program. The advisory council shall consist of:

(a) A representative of lending institutions, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Bankers Association.

(b) A representative of residential property insurers, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Insurance Council.

(c) A representative of home builders, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Home Builders Association.

(d) A faculty member of a state university, selected by the Financial Services Commission, who is an expert in hurricane-resistant construction methodologies and materials.

(e) Two members of the House of Representatives, selected by the Speaker of the House of Representatives.

(f) Two members of the Senate, selected by the President of the Senate.

(g) The Chief Executive Officer of the Federal Alliance for Safe Homes, Inc., or his or her designee.

(h) The senior officer of the Florida Hurricane Catastrophe Fund.

(i) The executive director of Citizens Property Insurance Corporation.

(j) The director of the Division of Emergency Management of the Department of Community Affairs.

Members appointed under paragraphs (a)-(d) shall serve at the pleasure of the Financial Services Commission. Members appointed under paragraphs (e) and (f) shall serve at the pleasure of the appointing officer. All other members shall serve voting ex officio. Members of the advisory council shall serve without compensation but may receive reimbursement as provided in s. 112.061 for per diem and travel expenses incurred in the performance of their official duties.

(5) FUNDING.--The department may seek out and leverage local, state, federal, or private funds to enhance the financial resources of the program.

(6) RULES.--The Department of Financial Services shall adopt rules pursuant to ss. 120.536(1) and 120.54 to govern the program; implement the provisions of this section; including rules governing hurricane mitigation inspections, mitigation contractors, and training of inspectors and contractors; and carry out the duties of the department under this section.

(7) HURRICANE MITIGATION INSPECTOR LIST.--The department shall develop and maintain as a public record a current list of hurricane mitigation inspectors authorized to conduct hurricane mitigation inspections pursuant to this section.

(8) NO-INTEREST LOANS.--The department shall implement a no-interest loan program by October 1, 2008, contingent upon the selection of a qualified vendor and execution of a contract acceptable to the department and the vendor. The department shall enter into partnerships with the private sector to provide loans to owners of site-built, single-family, residential property to pay for mitigation measures listed in subsection (2). A loan eligible for interest payments pursuant to this subsection may be for a term of up to 3 years and cover up to $5,000 in mitigation measures. The department shall pay the creditor the market rate of interest using funds appropriated for the My Safe Florida Home Program. In no case shall the department pay more than the interest rate set by s. 687.03. To be eligible for a loan, a loan applicant must first obtain a home inspection and report that specifies what improvements are needed to reduce the property's vulnerability to windstorm damage pursuant to this section and meet loan underwriting requirements set by the lender. The department shall set aside $10 million from funds appropriated for the My Safe Florida Home Program to implement this subsection. The department may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection which may include eligibility criteria.

(9) PUBLIC OUTREACH FOR CONTRACTORS AND REAL ESTATE BROKERS AND SALES ASSOCIATES.--The program shall develop brochures for distribution to general contractors, roofing contractors, and real estate brokers and sales associates licensed under part I of chapter 475 explaining the benefits to homeowners of residential hurricane damage mitigation. The program shall encourage contractors to distribute the brochures to homeowners at the first meeting with a homeowner who is considering contracting for home or roof repairs or contracting for the construction of a new home. The program shall encourage real estate brokers and sales associates licensed under part I of chapter 475 to distribute the brochures to clients prior to the purchase of a home. The brochures may be made available electronically.

(10) CONTRACT MANAGEMENT.--The department may contract with third parties for grants management, inspection services, contractor services for low-income homeowners, information technology, educational outreach, and auditing services. Such contracts shall be considered direct costs of the program and shall not be subject to administrative cost limits, but contracts valued at $500,000 or more shall be subject to review and approval by the Legislative Budget Commission. The department shall contract with providers that have a demonstrated record of successful business operations in areas directly related to the services to be provided and shall ensure the highest accountability for use of state funds, consistent with this section.

(11) INTENT.--It is the intent of the Legislature that grants made to residential property owners under this section shall be considered disaster-relief assistance within the meaning of s. 139 of the Internal Revenue Code of 1986, as amended.

(12) REPORTS.--The department shall make an annual report on the activities of the program that shall account for the use of state funds and indicate the number of inspections requested, the number of inspections performed, the number of grant applications received, and the number and value of grants approved. The report shall be delivered to the President of the Senate and the Speaker of the House of Representatives by February 1 of each year.

624.307 General powers; duties.--

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

624.424 Annual statement and other information.--

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office or such organization as the office may designate all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, under criteria established by rule of the commission. In adopting the rule, the commission must consider any criteria established by the National Association of Insurance Commissioners. The office may require semiannual updates of the annual statement of opinion as to a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance or title insurance.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in

writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 7 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 2 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to implement this subsection, which rules must be in substantial conformity with the 1998 Model Rule Requiring Annual Audited Financial Reports

adopted by the National Association of Insurance Commissioners, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. No insurer may raise as a defense in any action, any exception to, waiver of, or interpretation of accounting requirements, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

627.062 Rate standards.--

(1) The rates for all classes of insurance to which the provisions of this part are applicable shall not be excessive, inadequate, or unfairly discriminatory.

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on such classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, shall be filed with the office under one of the following procedures except as provided in subparagraph 3.:

1. If the filing is made at least 90 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, then such filing shall be considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings shall not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with the provisions of subparagraph 1., such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before December 31, 2009, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered to be property coverages.

(b) Upon receiving a rate filing, the office shall review the rate filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk insured.

4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used to calculate insurance rates. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus may not be considered.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance. The office shall not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.

12. A reasonable margin for underwriting profit and contingencies.

13. The cost of medical services, if applicable.

14. Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

(c) In the case of fire insurance rates, consideration shall be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are given consideration by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and shall maintain the premium in a catastrophe reserve. Any removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes shall be subject to approval of the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes shall be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), a rate may be found by the office to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to the procedures of paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer shall not alter the rate except to conform with the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, the office shall not prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing.

(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

The provisions of this subsection shall not apply to workers' compensation and employer's liability insurance and to motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and which have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for a period of at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section. In order to enhance the ability of consumers to compare premiums and to increase the accuracy and usefulness of rate-comparison information provided by the office to the public, the office shall develop a proposed standard rating territory plan to be used by all authorized property and casualty insurers for residential property insurance. In adopting the proposed plan, the office may consider geographical characteristics relevant to risk, county lines, major roadways, existing rating territories used by a significant segment of the market, and other relevant factors. Such plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives by January 15, 2006. The plan may not be implemented unless authorized by further act of the Legislature.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the Florida Hurricane Catastrophe Fund, together with reasonable costs of other reinsurance, but may not recoup reinsurance costs that duplicate coverage provided by the Florida Hurricane Catastrophe Fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium and any over-recoupment shall be subtracted from the following year's reimbursement premium.

(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30

days after the receipt of the formal request and shall enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall be allowed 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request a expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.

(7)(a) The provisions of this subsection apply only with respect to rates for medical malpractice insurance and shall control to the extent of any conflict with other provisions of this section.

(b) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements may not be included in the insurer's rate base and may not be utilized to justify a rate or rate change.

(c) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, either using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.

(d) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.

(e) The insurer must apply a discount or surcharge based on the health care provider's loss experience or shall establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and must provide a copy of such schedule or description, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(f) Each medical malpractice insurer must make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.

(8)(a)1. No later than 60 days after the effective date of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature, the office shall calculate a presumed factor that reflects the impact that the changes contained in such legislation will have on rates for medical malpractice insurance and shall issue a notice informing all insurers writing medical malpractice coverage of such presumed factor. In determining the presumed factor, the office shall use generally accepted actuarial techniques and standards provided in this section in determining the expected impact on losses, expenses, and investment income of the insurer. To the extent that the operation of a provision of medical malpractice legislation

enacted during the 2003 Special Session D of the Florida Legislature is stayed pending a constitutional challenge, the impact of that provision shall not be included in the calculation of a presumed factor under this subparagraph.

2. No later than 60 days after the office issues its notice of the presumed rate change factor under subparagraph 1., each insurer writing medical malpractice coverage in this state shall submit to the office a rate filing for medical malpractice insurance, which will take effect no later than January 1, 2004, and apply retroactively to policies issued or renewed on or after the effective date of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature. Except as authorized under paragraph (b), the filing shall reflect an overall rate reduction at least as great as the presumed factor determined under subparagraph 1. With respect to policies issued on or after the effective date of such legislation and prior to the effective date of the rate filing required by this subsection, the office shall order the insurer to make a refund of the amount that was charged in excess of the rate that is approved.

(b) Any insurer or rating organization that contends that the rate provided for in paragraph (a) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques provided in this section in making any filing pursuant to this subsection. The office shall review each such exception and approve or disapprove it prior to use. It shall be the insurer's burden to actuarially justify any deviations from the rates required to be filed under paragraph (a). The insurer making a filing under this paragraph shall include in the filing the expected impact of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature on losses, expenses, and rates.

(c) If any provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is held invalid by a court of competent jurisdiction, the office shall permit an adjustment of all medical malpractice rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.

(d) Rates approved on or before July 1, 2003, for medical malpractice insurance shall remain in effect until the effective date of a new rate filing approved under this subsection.

(e) The calculation and notice by the office of the presumed factor pursuant to paragraph (a) is not an order or rule that is subject to chapter 120. If the office enters into a contract with an independent consultant to assist the office in calculating the presumed factor, such contract shall not be subject to the competitive solicitation requirements of s. 287.057.

(9)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a rate filing:

1. The signing officer and actuary have reviewed the rate filing;

2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading;

3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and

4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.

(b) A signing officer or actuary knowingly making a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.

(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.

(d) The commission may adopt rules and forms pursuant to ss. 120.536(1) and 120.54 to administer this subsection.

(10) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide to the office such loss and expense information as the office reasonably needs to meet this burden.

(11) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.0629 Residential property insurance; rate filings.--

(1)(a) It is the intent of the Legislature that insurers must provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques shall include, but not be limited to, fixtures or construction techniques which enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques which meet the minimum requirements of the Florida Building Code must be included in the rate filing. All insurance companies must make a rate filing which includes the credits, discounts, or other rate differentials or reductions in deductibles by February 28, 2003. By July 1, 2007, the office shall reevaluate the discounts, credits, other rate differentials, and appropriate reductions in deductibles for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code, based upon actual experience or any other loss relativity studies available to the office. The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings.

(b) By February 1, 2011, the Office of Insurance Regulation, in consultation with the Department of Financial Services and the Department of Community Affairs, shall develop and make publicly available a proposed method for insurers to establish discounts, credits, or other rate differentials for hurricane mitigation measures which directly correlate to the numerical

rating assigned to a structure pursuant to the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865, including any proposed changes to the uniform home grading scale. By October 1, 2011, the commission shall adopt rules requiring insurers to make rate filings for residential property insurance which revise insurers' discounts, credits, or other rate differentials for hurricane mitigation measures so that such rate differentials correlate directly to the uniform home grading scale. The rules may include such changes to the uniform home grading scale as the commission determines are necessary, and may specify the minimum required discounts, credits, or other rate differentials. Such rate differentials must be consistent with generally accepted actuarial principles and wind-loss mitigation studies. The rules shall allow a period of at least 2 years after the effective date of the revised mitigation discounts, credits, or other rate differentials for a property owner to obtain an inspection or otherwise qualify for the revised credit, during which time the insurer shall continue to apply the mitigation credit that was applied immediately prior to the effective date of the revised credit.

(2)(a) A rate filing for residential property insurance made on or before the implementation of paragraph (b) may include rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses the risk of wind damage; however, such a rate filing must also provide for variations from such rate factors on an individual basis based on an inspection of a particular structure by a licensed home inspector, which inspection may be at the cost of the insured.

(b) A rate filing for residential property insurance made more than 150 days after approval by the office of a building code rating factor plan submitted by a statewide rating organization shall include positive and negative rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses risk of wind damage. The rate filing shall include variations from standard rate factors on an individual basis based on inspection of a particular structure by a licensed home inspector. If an inspection is requested by the insured, the insurer may require the insured to pay the reasonable cost of the inspection. This paragraph applies to structures constructed or renovated after the implementation of this paragraph.

(c) The premium notice shall specify the amount by which the rate has been adjusted as a result of this subsection and shall also specify the maximum possible positive and negative adjustments that are approved for use by the insurer under this subsection.

(3) A rate filing made on or after July 1, 1995, for mobile home owner's insurance must include appropriate discounts, credits, or other rate differentials for mobile homes constructed to comply with American Society of Civil Engineers Standard ANSI/ASCE 7-88, adopted by the United States Department of Housing and Urban Development on July 13, 1994, and that also comply with all applicable tie-down requirements provided by state law.

(4) The Legislature finds that separate consideration and notice of hurricane insurance premiums will assist consumers by providing greater assurance that hurricane premiums are lawful and by providing more complete information regarding the components of property insurance premiums. Effective January 1, 1997, a rate filing for residential property insurance shall be separated into two components, rates for hurricane coverage and rates for all other coverages. A premium notice reflecting a rate implemented on the basis of such a filing shall separately indicate the premium for hurricane coverage and the premium for all other coverages.

(5) In order to provide an appropriate transition period, an insurer may, in its sole discretion, implement an approved rate filing for residential property insurance over a period of years. An

insurer electing to phase in its rate filing must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing.

(6) Any rate filing that is based in whole or part on data from a computer model may not exceed 15 percent unless there is a public hearing.

(7) An insurer may implement appropriate discounts or other rate differentials of up to 10 percent of the annual premium to mobile home owners who provide to the insurer evidence of a current inspection of tie-downs for the mobile home, certifying that the tie-downs have been properly installed and are in good condition.

(8) EVALUATION OF RESIDENTIAL PROPERTY STRUCTURAL SOUNDNESS.--

(a) It is the intent of the Legislature to provide a program whereby homeowners may obtain an evaluation of the wind resistance of their homes with respect to preventing damage from hurricanes, together with a recommendation of reasonable steps that may be taken to upgrade their homes to better withstand hurricane force winds.

(b) To the extent that funds are provided for this purpose in the General Appropriations Act, the Legislature hereby authorizes the establishment of a program to be administered by the Citizens Property Insurance Corporation for homeowners insured in the high-risk account.

(c) The program shall provide grants to homeowners, for the purpose of providing homeowner applicants with funds to conduct an evaluation of the integrity of their homes with respect to withstanding hurricane force winds, recommendations to retrofit the homes to better withstand damage from such winds, and the estimated cost to make the recommended retrofits.

(d) The Department of Community Affairs shall establish by rule standards to govern the quality of the evaluation, the quality of the recommendations for retrofitting, the eligibility of the persons conducting the evaluation, and the selection of applicants under the program. In establishing the rule, the Department of Community Affairs shall consult with the advisory committee to minimize the possibility of fraud or abuse in the evaluation and retrofitting process, and to ensure that funds spent by homeowners acting on the recommendations achieve positive results.

(e) The Citizens Property Insurance Corporation shall identify areas of this state with the greatest wind risk to residential properties and recommend annually to the Department of Community Affairs priority target areas for such evaluations and inclusion with the associated residential construction mitigation program.

(9) A property insurance rate filing that includes any adjustments related to premiums paid to the Florida Hurricane Catastrophe Fund must include a complete calculation of the insurer's catastrophe load, and the information in the filing may not be limited solely to recovery of moneys paid to the fund.

627.0645 Annual filings.--

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

(b) Commercial property and casualty insurance as defined in s. 627.0625(1) other than commercial multiple line and commercial motor vehicle,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations filed by an insurer to any rating organization's base rate filing are not subject to this section.

(b) The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(3) The filing requirements of this section shall be satisfied by one of the following methods:

(a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory pursuant to the applicable rating laws and pursuant to rules of the commission.

(b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062.

(4) An insurer may satisfy the annual filing requirements of this section by being a member or subscriber of a licensed rating organization which complies with the requirements of this section.

(5) If an insurer does not employ or otherwise retain the services of an actuary, the insurer's rate filing or certification that rates are actuarially sound shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. A rate filing or certification prepared by a consultant must be reviewed and signed by an employee of the insurer who is authorized to approve rate filings.

(6) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(7) Nothing in this section limits the office's authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory pursuant to s. 627.062.

(8) As used in this section, the term "actuary" means an individual who is a member of the Casualty Actuarial Society.

(9) If an insurer fails to meet the filing requirements of this section and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for the line of insurance for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.--

(1) Using a form prescribed by the Office of Insurance Regulation, the insurer shall clearly notify the applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability and the range of each premium discount, credit, other rate differential, or reduction in deductibles, and combinations of discounts, credits, rate differentials, or reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed or implemented. The prescribed form shall describe generally what actions the policyholders may be able to take to reduce their windstorm premium. The prescribed form and a list of such ranges approved by the office for each insurer licensed in the state and providing such discounts, credits, other rate differentials, or reductions in deductibles for properties described in this subsection shall be available for electronic viewing and download from the Department of Financial Services' or the Office of Insurance Regulation's Internet website. The Financial Services Commission may adopt rules to implement this subsection.

(2) By July 1, 2007, the Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form certified by the Department of Financial Services or signed by:

(a) A hurricane mitigation inspector employed by an approved My Safe Florida Home wind certification entity;

(b) A building code inspector certified under s. 468.607;

(c) A general or residential contractor licensed under s. 489.111;

(d) A professional engineer licensed under s. 471.015 who has passed the appropriate equivalency test of the Building Code Training Program as required by s. 553.841; or

(e) A professional architect licensed under s. 481.213.

M E M O R A N D U M

DATE: November 3, 2009

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Steven H. Parton, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for November 17, 2009
Request for Approval to Publish Amendments to
Rule 69O-170.0155, Form OIR-B1-1802
Assmt. # 44304

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before November 12, 2009 and to the Financial Services Commission on November 17, 2009, with a request to approve for publication the proposed rules.

This rule is being amended to adopt a revised version of Office of Insurance Regulation form OIR-B1-1802, "Uniform Mitigation Verification Inspection Form". The form is being revised based on changes to the My Safe Florida Home program and the experience of the Office of Insurance Regulation, insurers and policyholders with the form since its last revision in July 2007.

Sections 624.308(1), 627.711,627.736, 215.5586, 624.307(1), 624.424, 627.062, 627.0629, 627.0645, 627.711, 627.736, F.S., provide rulemaking authority and laws implemented for this rule.

Stacy Wilhite is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Steven H. Parton, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-170.0155 Forms

The following forms are hereby adopted and incorporated by reference:

(1)(a) – (k) No change.

(l) OIR-B1-1802, "Uniform Mitigation Verification Inspection Form," (Rev. 9/09 ~~New 7/07~~).

(1)(m) – (n) No change.

(2)(a) – (b) No change.

Rulemaking ~~Specific~~ Authority: 624.308(1), 627.711, 627.736 F.S. Law Implemented: 215.5586, 624.307(1), 624.424, 627.062, 627.0629, 627.0645, 627.711, 627.736 F.S. History–New 6-19-03, Formerly 4-170.0155, Amended 2-23-06, 12-26-06, 6-12-07, 7-17-07, 9-5-07, 3-13-08, _____.

Uniform Mitigation Verification Inspection Form

Maintain a copy of this form with the insurance policy

Inspection Date:		
Owner Information		
Owner Name:		Contact Person:
Address:		Home Phone:
City:	Zip:	Work Phone:
County:		Cell Phone:
Insurance Company:		Policy #:
Year of Home:	# of Stories:	Email:

NOTE: If any misrepresentation, omission, concealment of fact, incorrect statement or failure to complete ALL items in this form renders the inspection invalid or ineligible for mitigation discounts, it will be the responsibility of the Qualified Inspector to re-inspect the premises at no additional cost to the insured.

1. **Building Code:** What building code was used to design and build the structure?

   ☐ A. 1994 South Florida Building Code (building permit application date of 9/1/1994 or later in Miami-Dade and Broward Counties (also known as the High Velocity Hurricane Zone (HVHZ))

   ☐ B. Building code prior to the 1994 South Florida Building Code (building permit application date of 8/31/1994 or earlier in Miami-Dade and Broward Counties (HVHZ)

   ☐ C. 2001 Florida Building Code (building permit application date of 3/1/2002 or later outside the HVHZ)

   ☐ D. Building code prior to the 2001 Florida Building Code (building permit application date of 2/28/2002 or earlier outside the HVHZ)

   ☐ E. Unknown or undetermined

2. **Predominant Roof Covering:**
   Permit Application Date : _____ or Date of Installation : _____

   ☐ A. At a minimum meets the 2001 Florida Building Code or the 1994 South Florida Building Code and as a Miami-Dade NOA or FBC 2001 Product Approval listing demonstrating compliance with ASTM D 3161 (enhanced for 110MPH), OR, ASTM D 7158 (F, G or H), OR, FBC TAS 100-95 and TAS 107-95, OR, FMRC 4470 and/or 4471 (for metal roofs)

   ☐ B. Does not meet the above minimum requirements

   ☐ C. Unknown or Undetermined

NOTE: At least one photo documenting the existence of the construction or mitigation attribute marked in Sections 3 through 10 is required to accompany this form.

3. **Roof Deck Attachment:** What is the **weakest** form of roof deck attachment?

   ☐ A. Plywood/OSB roof sheathing with a minimum thickness of 7/16" attached to the roof truss/rafter (spaced a maximum of 24" o.c.) by 8d common nails spaced 6" along the edge and 6" in the field. **-OR-** Dimensional lumber/Tongue & Groove decking with a minimum of 2 nails per board. **-OR-** Any system of screws, nails, adhesives, other deck fastening system or truss/rafter spacing that has an equivalent mean uplift resistance of 182 psf.

   ☐ B. Plywood/OSB roof sheathing with a minimum thickness of 7/16" attached to the roof truss/rafter (spaced a maximum of 24" o.c.) by 8d common nails spaced 6" along the edge and 12" in the field.**-OR-** Any system of screws, nails, adhesives, other deck fastening system or truss/rafter spacing that has an equivalent mean uplift resistance of 103 psf.

   ☐ C. Plywood/Oriented strand board (OSB) roof sheathing attached to the roof truss/rafter (spaced a maximum of 24" o.c.) by staples or 6d nails spaced at 6" along the edge and 12" in the field. **-OR-** Batten decking supporting wood shakes or wood shingles.**-OR-** Any system of screws, nails, adhesives, other deck fastening system or truss/rafter spacing that has an equivalent mean uplift resistance of 55 psf.

Inspectors Initials _____ **Property Address**_____

☐ D. Reinforced Concrete Roof Deck.

☐ E. Other : _____

☐ F. Unknown or Unidentified

☐ G. No attic access

4. **Roof to Wall Attachment:** What is the **weakest** roof to wall connection?

☐ A. Toe Nails — Rafter/truss anchored to top plate of wall using nails driven at an angle through the rafter/truss and attached to the top plate of the wall.

☐ B. Clips — Metal attachments on **every** rafter/truss that are nailed to one side (or both sides in the case of a diamond type clip) of the rafter/truss and attached to the top plate of the wall frame or embedded in the bond beam.

☐ C. Single Wraps — Metal Straps must be secured to **every** rafter/truss with a minimum of 3 nails, wrapping over and securing to the opposite side of the rafter/truss with a minimum of 1 nail. The Strap must be attached to the top plate of the wall frame or embedded in the bond beam in at least one place.

☐ D. Double Wraps — Both Metal Straps must be secured to **every** rafter/truss with a minimum of 3 nails, wrapping over and securing to the opposite side of the rafter/truss with a minimum of 1 nail. Each Strap must be attached to the top plate of the wall frame or embedded in the bond beam in at least one place.

☐ E. Structural — Anchor bolts structurally connected or reinforced concrete roof.

☐ F. Other: _____

☐ G. Unknown or Unidentified

☐ H. No attic access

5. **Roof Geometry:** What is the roof shape(s)? (Porches or carports that are attached only to the fascia or wall of the host structure and not structurally connected to the main roof system are not considered in the roof geometry determination)

☐ A. Hip Roof — Hip roof with no other roof shapes greater than 10% of the total building perimeter.

☐ B. Non-Hip Roof — Any other roof shape or combination of roof shapes including hip, gable, gambrel, mansard and other roof shapes not including flat roofs.

☐ C. Flat Roof — Flat roof shape greater than 100 square feet or 10% of the entire roof, whichever is greater.

6. **Gable End Bracing:** For roof structures that contain gables, please check the **weakest** that apply:

☐ A. Gable End(s) are braced at a minimum in accordance with the 2001 Florida Building Code.

☐ B. Does not meet the above minimum requirements.

☐ C. Not applicable, unknown or unidentified.

7. **Wall Construction Type:** Check all wall construction types for exterior walls of the structure and percentages for each:

☐ A. Wood Frame _____%

☐ B. Un-Reinforced Masonry _____%

☐ C. Reinforced Masonry _____%

☐ D. Poured Concrete _____%

☐ E. Other: _____ _____%

8. **Secondary Water Resistance (SWR):** (standard underlayments or hot mopped felts are not SWR)

☐ A. SWR — Self adhering polymer modified bitumen roofing underlayment applied directly to the sheathing or foam adhesive SWR Barrier (not foamed on insulation) applied as a secondary means to protect the dwelling from water intrusion.

☐ B. No SWR

☐ C. Unknown or undetermined

9. **Opening Protection:** What is the **weakest** form of wind borne debris protection installed on the structure? (Exterior openings include, but are not limited to: windows, doors, garage doors, skylights, etc. Product approval may be required for opening protection devices without proper rating identification)

Inspectors Initials ___ **Property Address**_____

☐ A. **All Exterior Openings (Glazed and Unglazed)** All exterior openings are fully protected at a minimum with impact resistant coverings, impact resistant doors and/or impact resistant window units that are listed as wind borne debris protection devices in the product approval system of the State of Florida or Miami-Dade County and meet the requirements of one of the following for "Cyclic Pressure and Large Missile Impact". For the HVHZ, systems must have either a Miami-Dade NOA or FBC Approval marked *"For Use in the HVHZ"*.

- ☐ Miami-Dade County Notice of Acceptance (NOA) 201, 202 **and** 203 (Large Missile - 9 lb)
- ☐ Florida Building Code Testing Application Standard (TAS) 201, 202 **and** 203 (Large Missile – 9 lb.)
- ☐ American Society for Testing and Materials (ASTM) E 1886 **and** ASTM E 1996 (Large Missile – 9 lb.)
- ☐ Southern Standards Technical Document (SSTD) 12 (Large Missile – 9 lb.)
- ☐ For Skylights Only: ASTM E 1886/E 1996 (Large Missile - 4.5 lb.)
- ☐ For Garage Doors Only: ANSI/DASMA 115 (Large Missile – 9 lb)

☐ B. **All exterior openings** are fully protected at a minimum with impact resistant coverings, impact resistant doors and/or impact resistant window units that are listed as windborne debris protection devices in the product approval system of the State of Florida or Miami-Dade County and meet the requirements of one of the following for "Cyclic Pressure and Large Missile Impact":

- ☐ ASTM E 1886 and ASTM E 1996 (Large Missile – 4.5 lb.)
- ☐ SSTD 12 (Large Missile – 4 lb. to 8 lb.)
- ☐ For Skylights Only: ASTM E 1886/E 1996 (Large Missile - 2 to 4.5 lb.)

☐ C. **All exterior openings** are fully protected at a minimum with impact resistant coverings, impact resistant doors and/or impact resistant window units that are listed as windborne debris protection devices in the product approval system of the State of Florida or Miami-Dade County and meet the requirements of one of the following for "Cyclic Pressure and Small Missile Impact":

- ☐ Miami-Dade County NOA 201, 202 **and** 203 (Small Missile – 2grams)
- ☐ Florida Building Code TAS 201, 202 **and** 203 (Small Missile – 2 grams)
- ☐ ASTM E 1886 **and** ASTM E 1996 (Small Missile – 2 grams)
- ☐ SSTD 12 (Small Missile – 2 grams)

☐ D. **All exterior openings** are fully protected with windborne debris protection devices that cannot be indentified as Miami-Dade or Florida Building Code (FBC) product approved. This does not include after market applied window films (see Answer "K") –OR- plywood/OSB, or plywood alternatives (see Answer "H").

All Glazed Exterior Openings

☐ E. **All glazed exterior openings** are fully protected at a minimum with impact resistant coverings and/or impact resistant window units that meet the requirements of one of the standards listed under Answer "A" of this question. (Large Missile – 9 lb.)

☐ F. **All glazed exterior openings** are fully protected at a minimum with impact resistant coverings and/or impact resistant window units that meet the requirements of one of the standards listed under Answer "B" of this question. (Large Missile – 2 lb. - 8 lb.)

☐ G. **All glazed exterior openings** are fully protected at a minimum with impact resistant coverings and/or impact resistant window units that meet the requirements of one of the standards listed under Answer "C" of this question. (Small Missile – 2 grams)

☐ H. **All glazed exterior openings** are covered with plywood/OSB meeting the requirements of Section 1609 and Table 1609.1.4 of the 2004 FBC. (with 2006 supplements)

☐ I. **All glazed exterior openings** are fully protected with wind-borne debris protection devices that cannot be identified as Miami-Dade or FBC product approved. This does not include after market applied window films (see Answer "K") -OR- plywood/OSB or other plywood alternatives that do not meet Answer H (see Answer "K").

None or Some Glaze Openings

☐ J. At least one glazed exterior opening does not have wind-borne debris protection.

Inspectors Initials ___ Property Address_____

☐ K. No glazed exterior openings have wind-borne debris protection. This includes after market applied window films, -OR- plywood/OSB, or plywood alternative systems that do not meet Answer "H"

☐ L. Unknown or undetermined

MITIGATION INSPECTIONS MUST BE CERTIFIED BY A QUALIFIED INSPECTOR. **Section 627.711(2), Florida Statutes, provides a listing of individuals who may sign this form.**		
Qualified Inspector Name:	License Type:	License # or MSFH certificate #:
Inspection Company:	Phone:	

I, _____(Print name of the individual who actually performed the inspection), personally conducted the inspection of the residence identified on this form and in my professional opinion, all the data I reported is true and correct.

Qualified Inspector – I am a (check one):

☐ Hurricane mitigation inspector certified by the My Safe Florida Home Program:

☐ Building code inspector certified under Section 468.607, Florida Statutes:

☐ General, building or residential contractor licensed under Section 489.111, Florida Statutes:

☐ Professional architect licensed under Section 481.213, Florida Statutes:

☐ Professional engineer licensed under Section 471.015, Florida Statutes.

NOTE: Pursuant to Section 627.711(2)(d), Florida Statutes, in order to sign this form you must check the below box:

☐ (Professional Engineers only) I, by my signature below certify that I have passed the appropriate equivalency test of the Building Code Training Program as required by Section 553.841, Florida Statutes.

☐ Other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete this form pursuant to Section 627.711(2)(f), Florida Statutes:

Individuals signing this form must have their license or certificate in an "Active" status at time of the inspection.

Qualified Inspector Signature: _____ **Date:** _____

An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled commits a misdemeanor of the first degree (Section 627.711(3), Florida Statutes). The Qualified Inspector who certifies this form is strictly liable for all acts, statements, concealment of facts, omissions, and documentation provided by their employee who actually performed the inspection.

Homeowner to complete: I certify that the named Qualified Inspector or an employee of the named Qualified Inspector did perform an inspection of the residence identified on this form and that proof of identification was provided to me or my Authorized Representative.

Signature: _____ **Date:** _____

An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled commits a misdemeanor of the first degree. (Section 627.711(3), Florida Statutes)

The definitions on this form are for inspection purposes only and cannot be used to certify any product or construction feature as offering protection from hurricanes.

Inspectors Initials ___ **Property Address** _____

OIR –B1- 1802 (Rev. 09/09) Adopted by Rule 69O-170.0155
***This verification form is valid up to five (5) years provided no material changes have been made to the structure.**

Specific Authority

624.308 Rules.--

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.--

(1) Using a form prescribed by the Office of Insurance Regulation, the insurer shall clearly notify the applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability and the range of each premium discount, credit, other rate differential, or reduction in deductibles, and combinations of discounts, credits, rate differentials, or reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed or implemented. The prescribed form shall describe generally what actions the policyholders may be able to take to reduce their windstorm premium. The prescribed form and a list of such ranges approved by the office for each insurer licensed in the state and providing such discounts, credits, other rate differentials, or reductions in deductibles for properties described in this subsection shall be available for electronic viewing and download from the Department of Financial Services' or the Office of Insurance Regulation's Internet website. The Financial Services Commission may adopt rules to implement this subsection.

(2) By July 1, 2007, the Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form certified by the Department of Financial Services or signed by:

(a) A hurricane mitigation inspector employed by an approved My Safe Florida Home wind certification entity;

(b) A building code inspector certified under s. 468.607;

(c) A general or residential contractor licensed under s. 489.111;

(d) A professional engineer licensed under s. 471.015 who has passed the appropriate equivalency test of the Building Code Training Program as required by s. 553.841; or

(e) A professional architect

(f) Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form.

(3) An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

licensed under s. 481.213.

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627.736 Required personal injury protection benefits; exclusions; priority; claims.--

(1) REQUIRED BENEFITS.--Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(e), to a limit of $10,000 for loss sustained by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*--Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. However, the medical benefits shall provide reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided by any of the following persons or entities:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.

3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.

4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under ss. 400.990-400.995 that is:

a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

b. A health care clinic that:

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

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(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) *Disability benefits.*--Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision shall be paid not less than every 2 weeks.

(c) *Death benefits.*--Death benefits equal to the lesser of $5,000 or the remainder of unused personal injury protection benefits per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

(2) AUTHORIZED EXCLUSIONS.--Any insurer may exclude benefits:

(a) For injury sustained by the named insured and relatives residing in the same household while occupying another motor vehicle owned by the named insured and not insured under the policy or for injury sustained by any person operating the insured motor vehicle without the express or implied consent of the insured.

(b) To any injured person, if such person's conduct contributed to his or her injury under any of the following circumstances:

1. Causing injury to himself or herself intentionally; or

2. Being injured while committing a felony.

Whenever an insured is charged with conduct as set forth in subparagraph 2., the 30-day payment provision of paragraph (4)(b) shall be held in abeyance, and the insurer shall withhold payment of any personal injury protection benefits pending the outcome of the case at the trial level. If the charge is nolle prossed or dismissed or the insured is acquitted, the 30-day payment provision shall run from the date the insurer is notified of such action.

(3) INSURED'S RIGHTS TO RECOVERY OF SPECIAL DAMAGES IN TORT CLAIMS.--No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise for personal injury protection benefits, whether suit has been filed or settlement has been reached without suit. An injured party who is entitled to bring suit under the provisions of ss. 627.730-627.7405, or his or her legal representative, shall have no right to recover any damages for which personal injury protection benefits are paid or payable. The plaintiff may prove all of his or her special damages notwithstanding this limitation, but if special damages are introduced in evidence, the trier of facts, whether judge or jury, shall not award damages for personal injury protection benefits paid or payable. In all cases in which a jury is required to fix damages, the court shall instruct the jury that the plaintiff shall not recover such special damages for personal injury protection benefits paid or payable.

(4) BENEFITS; WHEN DUE.--Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(a) An insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the policy affords the security required by ss. 627.730-627.7405.

(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. When an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desires the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, provided that this shall not limit the introduction of evidence at trial; and the insurer shall include the name and address of the person to whom the claimant should respond and a claim number to be referenced in future correspondence. However, notwithstanding the fact that written notice has been furnished to the insurer, any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is

equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion by the insurer may be made at any time, including after payment of the claim or after the 30-day time period for payment set forth in this paragraph.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002(9), or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of a claim from a physician or dentist who provided emergency services and care or who provided hospital inpatient care may then be used by the insurer to pay other claims. The time periods specified in paragraph (b) for required payment of personal injury protection benefits shall be tolled for the period of time that an insurer is required by this paragraph to hold payment of a claim that is not from a physician or dentist who provided emergency services and care or who provided hospital inpatient care to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(d) All overdue payments shall bear simple interest at the rate established under s. 55.03 or the rate established in the insurance contract, whichever is greater, for the year in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest shall be due at the time payment of the overdue claim is made.

(e) The insurer of the owner of a motor vehicle shall pay personal injury protection benefits for:

1. Accidental bodily injury sustained in this state by the owner while occupying a motor vehicle, or while not an occupant of a self-propelled vehicle if the injury is caused by physical contact with a motor vehicle.

2. Accidental bodily injury sustained outside this state, but within the United States of America or its territories or possessions or Canada, by the owner while occupying the owner's motor vehicle.

3. Accidental bodily injury sustained by a relative of the owner residing in the same household, under the circumstances described in subparagraph 1. or subparagraph 2., provided the relative at the time of the accident is domiciled in the owner's household and is not himself or herself the owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405.

4. Accidental bodily injury sustained in this state by any other person while occupying the owner's motor vehicle or, if a resident of this state, while not an occupant of a self-propelled vehicle, if the injury is caused by physical contact with such motor vehicle, provided the injured person is not himself or herself:

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a. The owner of a motor vehicle with respect to which security is required under ss. 627.730-627.7405; or

b. Entitled to personal injury benefits from the insurer of the owner or owners of such a motor vehicle.

(f) If two or more insurers are liable to pay personal injury protection benefits for the same injury to any one person, the maximum payable shall be as specified in subsection (1), and any insurer paying the benefits shall be entitled to recover from each of the other insurers an equitable pro rata share of the benefits paid and expenses incurred in processing the claim.

(g) It is a violation of the insurance code for an insurer to fail to timely provide benefits as required by this section with such frequency as to constitute a general business practice.

(h) Benefits shall not be due or payable to or on the behalf of an insured person if that person has committed, by a material act or omission, any insurance fraud relating to personal injury protection coverage under his or her policy, if the fraud is admitted to in a sworn statement by the insured or if it is established in a court of competent jurisdiction. Any insurance fraud shall void all coverage arising from the claim related to such fraud under the personal injury protection coverage of the insured person who committed the fraud, irrespective of whether a portion of the insured person's claim may be legitimate, and any benefits paid prior to the discovery of the insured person's insurance fraud shall be recoverable by the insurer from the person who committed insurance fraud in their entirety. The prevailing party is entitled to its costs and attorney's fees in any action in which it prevails in an insurer's action to enforce its right of recovery under this paragraph.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

(a)1. Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

2. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002(9) provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

3. For purposes of subparagraph 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered, except that it may not be less than the allowable amount under the participating physicians schedule [1]of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

4. Subparagraph 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

5. If an insurer limits payment as authorized by subparagraph 2., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

(b)1. An insurer or insured is not required to pay a claim or charges:

a. Made by a broker or by a person making a claim on behalf of a broker;

b. For any service or treatment that was not lawful at the time rendered;

c. To any person who knowingly submits a false or misleading statement relating to the claim or charges;

d. With respect to a bill or statement that does not substantially meet the applicable requirements of paragraph (d);

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e. For any treatment or service that is upcoded, or that is unbundled when such treatment or services should be bundled, in accordance with paragraph (d). To facilitate prompt payment of lawful services, an insurer may change codes that it determines to have been improperly or incorrectly upcoded or unbundled, and may make payment based on the changed codes, without affecting the right of the provider to dispute the change by the insurer, provided that before doing so, the insurer must contact the health care provider and discuss the reasons for the insurer's change and the health care provider's reason for the coding, or make a reasonable good faith effort to do so, as documented in the insurer's file; and

f. For medical services or treatment billed by a physician and not provided in a hospital unless such services are rendered by the physician or are incident to his or her professional services and are included on the physician's bill, including documentation verifying that the physician is responsible for the medical services that were rendered and billed.

2. The Department of Health, in consultation with the appropriate professional licensing boards, shall adopt, by rule, a list of diagnostic tests deemed not to be medically necessary for use in the treatment of persons sustaining bodily injury covered by personal injury protection benefits under this section. The initial list shall be adopted by January 1, 2004, and shall be revised from time to time as determined by the Department of Health, in consultation with the respective professional licensing boards. Inclusion of a test on the list of invalid diagnostic tests shall be based on lack of demonstrated medical value and a level of general acceptance by the relevant provider community and shall not be dependent for results entirely upon subjective patient response. Notwithstanding its inclusion on a fee schedule in this subsection, an insurer or insured is not required to pay any charges or reimburse claims for any invalid diagnostic test as determined by the Department of Health.

(c)1. With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay, charges for treatment or services rendered more than 35 days before the postmark date or electronic transmission date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The injured party is not liable for, and the provider shall not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable.

2. If, however, the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

a. A denial letter from the incorrect insurer; or

b. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.

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3. For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of charges within the time periods established by this paragraph; and the insurer shall not be considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph (d), or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Health Care Finance Administration.

4. Each notice of insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.--Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement.

(d) All statements and bills for medical services rendered by any physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office or adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers shall, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the Centers for Medicare and Medicaid Services (CMS) 1500 form instructions and the American Medical Association Current Procedural Terminology (CPT) Editorial Panel and Healthcare Correct Procedural Coding System (HCPCS). All providers other than hospitals shall include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the Physicians' Current Procedural Terminology (CPT) or the Healthcare Correct Procedural Coding System (HCPCS) in effect for the year in which services were rendered, the Office of the Inspector General (OIG), Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. No statement of medical services may include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer shall not be considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph, and unless the statements or bills are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

(e)1. At the initial treatment or service provided, each physician, other licensed professional, clinic, or other medical institution providing medical services upon which a claim for personal injury protection benefits is based shall require an insured person, or his or her guardian, to execute a disclosure and acknowledgment form, which reflects at a minimum that:

a. The insured, or his or her guardian, must countersign the form attesting to the fact that the services set forth therein were actually rendered;

b. The insured, or his or her guardian, has both the right and affirmative duty to confirm that the services were actually rendered;

c. The insured, or his or her guardian, was not solicited by any person to seek any services from the medical provider;

d. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed explained the services to the insured or his or her guardian; and

e. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

2. The physician, other licensed professional, clinic, or other medical institution rendering services for which payment is being claimed has the affirmative duty to explain the services rendered to the insured, or his or her guardian, so that the insured, or his or her guardian, countersigns the form with informed consent.

3. Countersignature by the insured, or his or her guardian, is not required for the reading of diagnostic tests or other services that are of such a nature that they are not required to be performed in the presence of the insured.

4. The licensed medical professional rendering treatment for which payment is being claimed must sign, by his or her own hand, the form complying with this paragraph.

5. The original completed disclosure and acknowledgment form shall be furnished to the insurer pursuant to paragraph (4)(b) and may not be electronically furnished.

6. This disclosure and acknowledgment form is not required for services billed by a provider for emergency services as defined in s. 395.002, for emergency services and care as defined in s. 395.002 rendered in a hospital emergency department, or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401.

7. The Financial Services Commission shall adopt, by rule, a standard disclosure and acknowledgment form that shall be used to fulfill the requirements of this paragraph, effective 90 days after such form is adopted and becomes final. The commission shall adopt a proposed rule by October 1, 2003. Until the rule is final, the provider may use a form of its own which otherwise complies with the requirements of this paragraph.

8. As used in this paragraph, "countersigned" means a second or verifying signature, as on a previously signed document, and is not satisfied by the statement "signature on file" or any similar statement.

9. The requirements of this paragraph apply only with respect to the initial treatment or service of the insured by a provider. For subsequent treatments or service, the provider must maintain a patient log signed by the patient, in chronological order by date of service, that is consistent with the services being rendered to the patient as claimed. The requirements of this subparagraph for maintaining a patient log signed by the patient may be met by a hospital that maintains medical records as required by s. 395.3025 and applicable rules and makes such records available to the insurer upon request.

(f) Upon written notification by any person, an insurer shall investigate any claim of improper billing by a physician or other medical provider. The insurer shall determine if the insured was properly billed for only those services and treatments that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured, the person making the written notification and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such written notification by any person, the insurer shall pay to the person 20 percent of the amount of the reduction, up to $500. If the provider is arrested due to the improper billing, then the insurer shall pay to the person 40 percent of the amount of the reduction, up to $500.

(g) An insurer may not systematically downcode with the intent to deny reimbursement otherwise due. Such action constitutes a material misrepresentation under s. 626.9541(1)(i)2.

(6) DISCOVERY OF FACTS ABOUT AN INJURED PERSON; DISPUTES.--

(a) Every employer shall, if a request is made by an insurer providing personal injury protection benefits under ss. 627.730-627.7405 against whom a claim has been made, furnish forthwith, in a form approved by the office, a sworn statement of the earnings, since the time of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

(b) Every physician, hospital, clinic, or other medical institution providing, before or after bodily injury upon which a claim for personal injury protection insurance benefits is based, any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates, and costs of such treatment of the injured person and why the items identified by the insurer were reasonable in amount and medically necessary, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the bodily injury sustained and identifying which portion of the expenses for such treatment or services was incurred as a result of such bodily injury, and produce forthwith, and permit the inspection and copying of, his or her or its records regarding such history, condition, treatment, dates, and costs of treatment; provided that this shall not limit the introduction of evidence at trial. Such sworn statement shall read as follows: "Under penalty of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief." No cause of action for violation of the physician-patient privilege or invasion of the right of privacy shall be permitted against any physician, hospital, clinic, or other medical institution complying with the provisions of this section. The person requesting such records and such sworn statement shall pay all reasonable costs connected therewith. If an insurer makes a written request for documentation or information under this paragraph within 30 days after having received notice of the amount of a covered loss under paragraph (4)(a), the amount or the partial amount which is the subject of the insurer's inquiry shall become overdue if the insurer does not pay in accordance with paragraph (4)(b) or within 10 days after the insurer's receipt of the requested documentation or information, whichever occurs later. For purposes of this paragraph, the term "receipt" includes, but is not limited to, inspection and copying pursuant to this paragraph. Any insurer that requests documentation or information pertaining to reasonableness of charges or medical necessity under this paragraph without a reasonable basis for such requests as a general business practice is engaging in an unfair trade practice under the insurance code.

(c) In the event of any dispute regarding an insurer's right to discovery of facts under this section, the insurer may petition a court of competent jurisdiction to enter an order permitting such discovery. The order may be made only on motion for good cause shown and upon notice

to all persons having an interest, and it shall specify the time, place, manner, conditions, and scope of the discovery. Such court may, in order to protect against annoyance, embarrassment, or oppression, as justice requires, enter an order refusing discovery or specifying conditions of discovery and may order payments of costs and expenses of the proceeding, including reasonable fees for the appearance of attorneys at the proceedings, as justice requires.

(d) The injured person shall be furnished, upon request, a copy of all information obtained by the insurer under the provisions of this section, and shall pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim shall not be unreasonably withheld by an insured.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.--

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, then such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a Florida physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one that is prepared and signed by the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination and treatment records if reviewed and that has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment records the physician must have devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions or to the instruction of students in an accredited health professional school or accredited residency program or a clinical research program that is affiliated with an accredited health professional school or teaching hospital or accredited residency program. The physician preparing a report at the request of an insurer and physicians rendering expert opinions on behalf of persons claiming medical benefits for personal injury protection, or on behalf of an insured through an attorney or another entity, shall maintain, for at least 3 years, copies of all examination reports as medical records and shall maintain, for at least 3 years, records of all payments for the examinations and reports. Neither an insurer nor any person acting at the direction of or on behalf of an insurer may materially change an opinion in a report prepared under this paragraph or direct the physician preparing the report to change such opinion. The denial of a payment as the result of such a changed opinion constitutes a material misrepresentation under s. 626.9541(1)(i)2.; however, this provision does not preclude the insurer from calling to

the attention of the physician errors of fact in the report based upon information in the claim file.

(b) If requested by the person examined, a party causing an examination to be made shall deliver to him or her a copy of every written report concerning the examination rendered by an examining physician, at least one of which reports must set out the examining physician's findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled, upon request, to receive from the person examined every written report available to him or her or his or her representative concerning any examination, previously or thereafter made, of the same mental or physical condition. By requesting and obtaining a report of the examination so ordered, or by taking the deposition of the examiner, the person examined waives any privilege he or she may have, in relation to the claim for benefits, regarding the testimony of every other person who has examined, or may thereafter examine, him or her in respect to the same mental or physical condition. If a person unreasonably refuses to submit to an examination, the personal injury protection carrier is no longer liable for subsequent personal injury protection benefits.

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY'S FEES.--With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions of s. 627.428 shall apply, except as provided in subsections (10) and (15).

(9) An insurer may negotiate and enter into contracts with licensed health care providers for the benefits described in this section, referred to in this section as "preferred providers," which shall include health care providers licensed under chapters 458, 459, 460, 461, and 463. The insurer may provide an option to an insured to use a preferred provider at the time of purchase of the policy for personal injury protection benefits, if the requirements of this subsection are met. If the insured elects to use a provider who is not a preferred provider, whether the insured purchased a preferred provider policy or a nonpreferred provider policy, the medical benefits provided by the insurer shall be as required by this section. If the insured elects to use a provider who is a preferred provider, the insurer may pay medical benefits in excess of the benefits required by this section and may waive or lower the amount of any deductible that applies to such medical benefits. If the insurer offers a preferred provider policy to a policyholder or applicant, it must also offer a nonpreferred provider policy. The insurer shall provide each policyholder with a current roster of preferred providers in the county in which the insured resides at the time of purchase of such policy, and shall make such list available for public inspection during regular business hours at the principal office of the insurer within the state.

(10) DEMAND LETTER.--

(a) As a condition precedent to filing any action for benefits under this section, the insurer must be provided with written notice of an intent to initiate litigation. Such notice may not be sent until the claim is overdue, including any additional time the insurer has to pay the claim pursuant to paragraph (4)(b).

(b) The notice required shall state that it is a "demand letter under s. 627.736(10)" and shall state with specificity:

1. The name of the insured upon which such benefits are being sought, including a copy of the assignment giving rights to the claimant if the claimant is not the insured.

2. The claim number or policy number upon which such claim was originally submitted to the insurer.

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3. To the extent applicable, the name of any medical provider who rendered to an insured the treatment, services, accommodations, or supplies that form the basis of such claim; and an itemized statement specifying each exact amount, the date of treatment, service, or accommodation, and the type of benefit claimed to be due. A completed form satisfying the requirements of paragraph (5)(d) or the lost-wage statement previously submitted may be used as the itemized statement. To the extent that the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, the claimant shall attach a copy of the insurer's notice withdrawing such payment and an itemized statement of the type, frequency, and duration of future treatment claimed to be reasonable and medically necessary.

(c) Each notice required by this subsection must be delivered to the insurer by United States certified or registered mail, return receipt requested. Such postal costs shall be reimbursed by the insurer if so requested by the claimant in the notice, when the insurer pays the claim. Such notice must be sent to the person and address specified by the insurer for the purposes of receiving notices under this subsection. Each licensed insurer, whether domestic, foreign, or alien, shall file with the office designation of the name and address of the person to whom notices pursuant to this subsection shall be sent which the office shall make available on its Internet website. The name and address on file with the office pursuant to s. 624.422 shall be deemed the authorized representative to accept notice pursuant to this subsection in the event no other designation has been made.

(d) If, within 30 days after receipt of notice by the insurer, the overdue claim specified in the notice is paid by the insurer together with applicable interest and a penalty of 10 percent of the overdue amount paid by the insurer, subject to a maximum penalty of $250, no action may be brought against the insurer. If the demand involves an insurer's withdrawal of payment under paragraph (7)(a) for future treatment not yet rendered, no action may be brought against the insurer if, within 30 days after its receipt of the notice, the insurer mails to the person filing the notice a written statement of the insurer's agreement to pay for such treatment in accordance with the notice and to pay a penalty of 10 percent, subject to a maximum penalty of $250, when it pays for such future treatment in accordance with the requirements of this section. To the extent the insurer determines not to pay any amount demanded, the penalty shall not be payable in any subsequent action. For purposes of this subsection, payment or the insurer's agreement shall be treated as being made on the date a draft or other valid instrument that is equivalent to payment, or the insurer's written statement of agreement, is placed in the United States mail in a properly addressed, postpaid envelope, or if not so posted, on the date of delivery. The insurer is not obligated to pay any attorney's fees if the insurer pays the claim or mails its agreement to pay for future treatment within the time prescribed by this subsection.

(e) The applicable statute of limitation for an action under this section shall be tolled for a period of 30 business days by the mailing of the notice required by this subsection.

(f) Any insurer making a general business practice of not paying valid claims until receipt of the notice required by this subsection is engaging in an unfair trade practice under the insurance code.

(11) FAILURE TO PAY VALID CLAIMS; UNFAIR OR DECEPTIVE PRACTICE.--

(a) If an insurer fails to pay valid claims for personal injury protection with such frequency so as to indicate a general business practice, the insurer is engaging in a prohibited unfair or deceptive practice that is subject to the penalties provided in s. 626.9521 and the office has the powers and duties specified in ss. 626.9561-626.9601 with respect thereto.

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(b) Notwithstanding s. 501.212, the Department of Legal Affairs may investigate and initiate actions for a violation of this subsection, including, but not limited to, the powers and duties specified in part II of chapter 501.

(12) CIVIL ACTION FOR INSURANCE FRAUD.--An insurer shall have a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section. An insurer prevailing in an action brought under this subsection may recover compensatory, consequential, and punitive damages subject to the requirements and limitations of part II of chapter 768, and attorney's fees and costs incurred in litigating a cause of action against any person convicted of, or who, regardless of adjudication of guilt, pleads guilty or nolo contendere to insurance fraud under s. 817.234, patient brokering under s. 817.505, or kickbacks under s. 456.054, associated with a claim for personal injury protection benefits in accordance with this section.

(13) MINIMUM BENEFIT COVERAGE.--If the Financial Services Commission determines that the cost savings under personal injury protection insurance benefits paid by insurers have been realized due to the provisions of this act, prior legislative reforms, or other factors, the commission may increase the minimum $10,000 benefit coverage requirement. In establishing the amount of such increase, the commission must determine that the additional premium for such coverage is approximately equal to the premium cost savings that have been realized for the personal injury protection coverage with limits of $10,000.

(14) FRAUD ADVISORY NOTICE.--Upon receiving notice of a claim under this section, an insurer shall provide a notice to the insured or to a person for whom a claim for reimbursement for diagnosis or treatment of injuries has been filed, advising that:

(a) Pursuant to s. 626.9892, the Department of Financial Services may pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing crimes investigated by the Division of Insurance Fraud arising from violations of s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.

(b) Solicitation of a person injured in a motor vehicle crash for purposes of filing personal injury protection or tort claims could be a violation of s. 817.234, s. 817.505, or the rules regulating The Florida Bar and should be immediately reported to the Division of Insurance Fraud if such conduct has taken place.

(15) ALL CLAIMS BROUGHT IN A SINGLE ACTION.--In any civil action to recover personal injury protection benefits brought by a claimant pursuant to this section against an insurer, all claims related to the same health care provider for the same injured person shall be brought in one action, unless good cause is shown why such claims should be brought separately. If the court determines that a civil action is filed for a claim that should have been brought in a prior civil action, the court may not award attorney's fees to the claimant.

(16) SECURE ELECTRONIC DATA TRANSFER.--If all parties mutually and expressly agree, a notice, documentation, transmission, or communication of any kind required or authorized under ss. 627.730-627.7405 may be transmitted electronically if it is transmitted by secure electronic data transfer that is consistent with state and federal privacy and security laws.

215.5586 My Safe Florida Home Program.--There is established within the Department of Financial Services the My Safe Florida Home Program. The department shall provide fiscal accountability, contract management, and strategic leadership for the program, consistent with this section. This section does not create an entitlement for property owners or obligate

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the state in any way to fund the inspection or retrofitting of residential property in this state. Implementation of this program is subject to annual legislative appropriations. It is the intent of the Legislature that the My Safe Florida Home Program provide inspections for at least 400,000 site-built, single-family, residential properties and provide grants to at least 35,000 applicants before June 30, 2009. The program shall develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that shall include the following:

(1) HURRICANE MITIGATION INSPECTIONS.--

(a) Free home-retrofit inspections of site-built, single-family, residential property shall be offered throughout the state to determine what mitigation measures are needed, what insurance premium discounts may be available, and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. The Department of Financial Services shall contract with wind certification entities to provide free hurricane mitigation inspections. The inspections provided to homeowners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies recommended improvements a homeowner may take to mitigate hurricane damage.

2. A range of cost estimates regarding the recommended mitigation improvements.

3. Insurer-specific information regarding premium discounts correlated to the current mitigation features and the recommended mitigation improvements identified by the inspection.

4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities. As soon as practical, the rating scale must be the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865.

(b) To qualify for selection by the department as a wind certification entity to provide hurricane mitigation inspections, the entity shall, at a minimum, meet the following requirements:

1. Use hurricane mitigation inspectors who:

a. Are certified as a building inspector under s. 468.607;

b. Are licensed as a general or residential contractor under s. 489.111;

c. Are licensed as a professional engineer under s. 471.015 and who have passed the appropriate equivalency test of the Building Code Training Program as required by s. 553.841;

d. Are licensed as a professional architect under s. 481.213; or

e. Have at least 2 years of experience in residential construction or residential building inspection and have received specialized training in hurricane mitigation procedures. Such training may be provided by a class offered online or in person.

2. Use hurricane mitigation inspectors who also:

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a. Have undergone drug testing and level 2 background checks pursuant to s. 435.04. The department may conduct criminal record checks of inspectors used by wind certification entities. Inspectors must submit a set of the fingerprints to the department for state and national criminal history checks and must pay the fingerprint processing fee set forth in s. 624.501. The fingerprints shall be sent by the department to the Department of Law Enforcement and forwarded to the Federal Bureau of Investigation for processing. The results shall be returned to the department for screening. The fingerprints shall be taken by a law enforcement agency, designated examination center, or other department-approved entity; and

b. Have been certified, in a manner satisfactory to the department, to conduct the inspections.

3. Provide a quality assurance program including a reinspection component.

(c) The department shall implement a quality assurance program that includes a statistically valid number of reinspections.

(d) An application for an inspection must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application for that home.

(e) The owner of a site-built, single-family, residential property may apply for and receive an inspection without also applying for a grant pursuant to subsection (2) and without meeting the requirements of paragraph (2)(a).

(2) MITIGATION GRANTS.--Financial grants shall be used to encourage single-family, site-built, owner-occupied, residential property owners to retrofit their properties to make them less vulnerable to hurricane damage.

(a) To be eligible for a grant for persons who have obtained a completed inspection after May 1, 2007, a residential property must:

1. Have been granted a homestead exemption under chapter 196.

2. Be a dwelling with an insured value of $300,000 or less. Homeowners who are low-income persons, as defined in s. 420.0004(10), are exempt from this requirement.

3. Have undergone an acceptable hurricane mitigation inspection.

4. Be located in the "wind-borne debris region" as that term is defined in s. 1609.2, International Building Code (2006).

5. Be a home for which the building permit application for initial construction was made before March 1, 2002.

An application for a grant must contain a signed or electronically verified statement made under penalty of perjury that the applicant has submitted only a single application and must have attached documents demonstrating the applicant meets the requirements of this paragraph.

(b) All grants must be matched on a dollar-for-dollar basis for a total of $10,000 for the actual cost of the mitigation project with the state's contribution not to exceed $5,000.

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(c) The program shall create a process in which contractors agree to participate and homeowners select from a list of participating contractors. All mitigation must be based upon the securing of all required local permits and inspections and must be performed by properly licensed contractors. Mitigation projects are subject to random reinspection of up to at least 5 percent of all projects. Hurricane mitigation inspectors qualifying for the program may also participate as mitigation contractors as long as the inspectors meet the department's qualifications and certification requirements for mitigation contractors.

(d) Matching fund grants shall also be made available to local governments and nonprofit entities for projects that will reduce hurricane damage to single-family, site-built, owner-occupied, residential property. The department shall liberally construe those requirements in favor of availing the state of the opportunity to leverage funding for the My Safe Florida Home Program with other sources of funding.

(e) When recommended by a hurricane mitigation inspection, grants may be used for the following improvements only:

1. Opening protection.

2. Exterior doors, including garage doors.

3. Brace gable ends.

The department may require that improvements be made to all openings, including exterior doors and garage doors, as a condition of reimbursing a homeowner approved for a grant.

(f) Grants may be used on a previously inspected existing structure or on a rebuild. A rebuild is defined as a site-built, single-family dwelling under construction to replace a home that was destroyed or significantly damaged by a hurricane and deemed unlivable by a regulatory authority. The homeowner must be a low-income homeowner as defined in paragraph (g), must have had a homestead exemption for that home prior to the hurricane, and must be intending to rebuild the home as that homeowner's homestead.

(g) Low-income homeowners, as defined in s. 420.0004(10), who otherwise meet the requirements of paragraphs (a), (c), (e), and (f) are eligible for a grant of up to $5,000 and are not required to provide a matching amount to receive the grant. Additionally, for low-income homeowners, grant funding may be used for repair to existing structures leading to any of the mitigation improvements provided in paragraph (e), limited to 20 percent of the grant value. The program may accept a certification directly from a low-income homeowner that the homeowner meets the requirements of s. 420.0004(10) if the homeowner provides such certification in a signed or electronically verified statement made under penalty of perjury.

(h) The department shall establish objective, reasonable criteria for prioritizing grant applications, consistent with the requirements of this section.

(i) The department shall develop a process that ensures the most efficient means to collect and verify grant applications to determine eligibility and may direct hurricane mitigation inspectors to collect and verify grant application information or use the Internet or other electronic means to collect information and determine eligibility.

(3) EDUCATION AND CONSUMER AWARENESS.--The department may undertake a statewide multimedia public outreach and advertising campaign to inform consumers of the availability and benefits of hurricane inspections and of the safety and financial benefits of residential

hurricane damage mitigation. The department may seek out and use local, state, federal, and private funds to support the campaign.

(4) ADVISORY COUNCIL.--There is created an advisory council to provide advice and assistance to the department regarding administration of the program. The advisory council shall consist of:

(a) A representative of lending institutions, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Bankers Association.

(b) A representative of residential property insurers, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Insurance Council.

(c) A representative of home builders, selected by the Financial Services Commission from a list of at least three persons recommended by the Florida Home Builders Association.

(d) A faculty member of a state university, selected by the Financial Services Commission, who is an expert in hurricane-resistant construction methodologies and materials.

(e) Two members of the House of Representatives, selected by the Speaker of the House of Representatives.

(f) Two members of the Senate, selected by the President of the Senate.

(g) The Chief Executive Officer of the Federal Alliance for Safe Homes, Inc., or his or her designee.

(h) The senior officer of the Florida Hurricane Catastrophe Fund.

(i) The executive director of Citizens Property Insurance Corporation.

(j) The director of the Division of Emergency Management of the Department of Community Affairs.

Members appointed under paragraphs (a)-(d) shall serve at the pleasure of the Financial Services Commission. Members appointed under paragraphs (e) and (f) shall serve at the pleasure of the appointing officer. All other members shall serve voting ex officio. Members of the advisory council shall serve without compensation but may receive reimbursement as provided in s. 112.061 for per diem and travel expenses incurred in the performance of their official duties.

(5) FUNDING.--The department may seek out and leverage local, state, federal, or private funds to enhance the financial resources of the program.

(6) RULES.--The Department of Financial Services shall adopt rules pursuant to ss. 120.536(1) and 120.54 to govern the program; implement the provisions of this section; including rules governing hurricane mitigation inspections, mitigation contractors, and training of inspectors and contractors; and carry out the duties of the department under this section.

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(7) HURRICANE MITIGATION INSPECTOR LIST.--The department shall develop and maintain as a public record a current list of hurricane mitigation inspectors authorized to conduct hurricane mitigation inspections pursuant to this section.

(8) NO-INTEREST LOANS.--The department shall implement a no-interest loan program by October 1, 2008, contingent upon the selection of a qualified vendor and execution of a contract acceptable to the department and the vendor. The department shall enter into partnerships with the private sector to provide loans to owners of site-built, single-family, residential property to pay for mitigation measures listed in subsection (2). A loan eligible for interest payments pursuant to this subsection may be for a term of up to 3 years and cover up to $5,000 in mitigation measures. The department shall pay the creditor the market rate of interest using funds appropriated for the My Safe Florida Home Program. In no case shall the department pay more than the interest rate set by s. 687.03. To be eligible for a loan, a loan applicant must first obtain a home inspection and report that specifies what improvements are needed to reduce the property's vulnerability to windstorm damage pursuant to this section and meet loan underwriting requirements set by the lender. The department shall set aside $10 million from funds appropriated for the My Safe Florida Home Program to implement this subsection. The department may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection which may include eligibility criteria.

(9) PUBLIC OUTREACH FOR CONTRACTORS AND REAL ESTATE BROKERS AND SALES ASSOCIATES.--The program shall develop brochures for distribution to general contractors, roofing contractors, and real estate brokers and sales associates licensed under part I of chapter 475 explaining the benefits to homeowners of residential hurricane damage mitigation. The program shall encourage contractors to distribute the brochures to homeowners at the first meeting with a homeowner who is considering contracting for home or roof repairs or contracting for the construction of a new home. The program shall encourage real estate brokers and sales associates licensed under part I of chapter 475 to distribute the brochures to clients prior to the purchase of a home. The brochures may be made available electronically.

(10) CONTRACT MANAGEMENT.--The department may contract with third parties for grants management, inspection services, contractor services for low-income homeowners, information technology, educational outreach, and auditing services. Such contracts shall be considered direct costs of the program and shall not be subject to administrative cost limits, but contracts valued at $500,000 or more shall be subject to review and approval by the Legislative Budget Commission. The department shall contract with providers that have a demonstrated record of successful business operations in areas directly related to the services to be provided and shall ensure the highest accountability for use of state funds, consistent with this section.

(11) INTENT.--It is the intent of the Legislature that grants made to residential property owners under this section shall be considered disaster-relief assistance within the meaning of s. 139 of the Internal Revenue Code of 1986, as amended.

(12) REPORTS.--The department shall make an annual report on the activities of the program that shall account for the use of state funds and indicate the number of inspections requested, the number of inspections performed, the number of grant applications received, and the number and value of grants approved. The report shall be delivered to the President of the Senate and the Speaker of the House of Representatives by February 1 of each year.

624.307 General powers; duties.--

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

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624.424 Annual statement and other information.--

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office or such organization as the office may designate all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, under criteria established by rule of the commission. In adopting the rule, the commission must consider any criteria established by the National Association of Insurance Commissioners. The office may require semiannual updates of the annual statement of opinion as to a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance or title insurance.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

(2) The statement of an alien insurer shall be verified by the insurer's United States manager or other officer duly authorized. It shall be a separate statement, to be known as its general statement, of its transactions, assets, and affairs within the United States unless the office requires otherwise. If the office requires a statement as to the insurer's affairs elsewhere, the insurer shall file such statement with the office as soon as reasonably possible.

(3) Each insurer having a deposit as required under s. 624.411 shall file with the office annually with its annual statement a certificate to the effect that the assets so deposited have a market value equal to or in excess of the amount of deposit so required.

(4) At the time of filing, the insurer shall pay the fee for filing its annual statement in the amount specified in s. 624.501.

(5) The office may refuse to continue, or may suspend or revoke, the certificate of authority of an insurer failing to file its annual or quarterly statements and accompanying certificates when due.

(6) In addition to information called for and furnished in connection with its annual or quarterly statements, an insurer shall furnish to the office as soon as reasonably possible such information as to its transactions or affairs as the office may from time to time request in

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writing. All such information furnished pursuant to the office's request shall be verified by the oath of two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(7) The signatures of all such persons when written on annual or quarterly statements or other reports required by this section shall be presumed to have been so written by authority of the person whose signature is affixed thereon. The affixing of any signature by anyone other than the purported signer constitutes a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(8)(a) All authorized insurers must have conducted an annual audit by an independent certified public accountant and must file an audited financial report with the office on or before June 1 for the preceding year ending December 31. The office may require an insurer to file an audited financial report earlier than June 1 upon 90 days' advance notice to the insurer. The office may immediately suspend an insurer's certificate of authority by order if an insurer's failure to file required reports, financial statements, or information required by this subsection or rule adopted pursuant thereto creates a significant uncertainty as to the insurer's continuing eligibility for a certificate of authority.

(b) Any authorized insurer otherwise subject to this section having direct premiums written in this state of less than $1 million in any calendar year and fewer than 1,000 policyholders or certificateholders of directly written policies nationwide at the end of such calendar year is exempt from this section for such year unless the office makes a specific finding that compliance is necessary in order for the office to carry out its statutory responsibilities. However, any insurer having assumed premiums pursuant to contracts or treaties or reinsurance of $1 million or more is not exempt. Any insurer subject to an exemption must submit by March 1 following the year to which the exemption applies an affidavit sworn to by a responsible officer of the insurer specifying the amount of direct premiums written in this state and number of policyholders or certificateholders.

(c) The board of directors of an insurer shall hire the certified public accountant that prepares the audit required by this subsection and the board shall establish an audit committee of three or more directors of the insurer or an affiliated company. The audit committee shall be responsible for discussing audit findings and interacting with the certified public accountant with regard to her or his findings. The audit committee shall be comprised solely of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member. The audit committee shall report to the board any findings of adverse financial conditions or significant deficiencies in internal controls that have been noted by the accountant. The insurer may request the office to waive this requirement of the audit committee membership based upon unusual hardship to the insurer.

(d) An insurer may not use the same accountant or partner of an accounting firm responsible for preparing the report required by this subsection for more than 7 consecutive years. Following this period, the insurer may not use such accountant or partner for a period of 2 years, but may use another accountant or partner of the same firm. An insurer may request the office to waive this prohibition based upon an unusual hardship to the insurer and a determination that the accountant is exercising independent judgment that is not unduly influenced by the insurer considering such factors as the number of partners, expertise of the partners or the number of insurance clients of the accounting firm; the premium volume of the insurer; and the number of jurisdictions in which the insurer transacts business.

(e) The commission shall adopt rules to implement this subsection, which rules must be in substantial conformity with the 1998 Model Rule Requiring Annual Audited Financial Reports

adopted by the National Association of Insurance Commissioners, except where inconsistent with the requirements of this subsection. Any exception to, waiver of, or interpretation of accounting requirements of the commission must be in writing and signed by an authorized representative of the office. No insurer may raise as a defense in any action, any exception to, waiver of, or interpretation of accounting requirements, unless previously issued in writing by an authorized representative of the office.

(9)(a) Each authorized insurer shall, pursuant to s. 409.910(20), provide records and information to the Agency for Health Care Administration to identify potential insurance coverage for claims filed with that agency and its fiscal agents for payment of medical services under the Medicaid program.

(b) Each authorized insurer shall, pursuant to s. 409.2561(5)(c), notify the Medicaid agency of a cancellation or discontinuance of a policy within 30 days if the insurer received notification from the Medicaid agency to do so.

(c) Any information provided by an insurer under this subsection does not violate any right of confidentiality or contract that the insurer may have with covered persons. The insurer is immune from any liability that it may otherwise incur through its release of such information to the Agency for Health Care Administration.

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

627.062 Rate standards.--

(1) The rates for all classes of insurance to which the provisions of this part are applicable shall not be excessive, inadequate, or unfairly discriminatory.

Specific Authority

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on such classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, shall be filed with the office under one of the following procedures except as provided in subparagraph 3.:

1. If the filing is made at least 90 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, then such filing shall be considered a "file and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings shall not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with the provisions of subparagraph 1., such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted after January 25, 2007, but before December 31, 2009, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered to be property coverages.

(b) Upon receiving a rate filing, the office shall review the rate filing to determine if a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk insured.

4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used to calculate insurance rates. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus may not be considered.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.

8. The cost of reinsurance. The office shall not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.

12. A reasonable margin for underwriting profit and contingencies.

13. The cost of medical services, if applicable.

14. Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

(c) In the case of fire insurance rates, consideration shall be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are given consideration by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and shall maintain the premium in a catastrophe reserve. Any removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes shall be subject to approval of the office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes shall be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), a rate may be found by the office to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.

Specific Authority

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.

6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to the procedures of paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer shall not alter the rate except to conform with the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

Specific Authority

(i) Except as otherwise specifically provided in this chapter, the office shall not prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing.

(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

The provisions of this subsection shall not apply to workers' compensation and employer's liability insurance and to motor vehicle insurance.

(3)(a) For individual risks that are not rated in accordance with the insurer's rates, rating schedules, rating manuals, and underwriting rules filed with the office and which have been submitted to the insurer for individual rating, the insurer must maintain documentation on each risk subject to individual risk rating. The documentation must identify the named insured and specify the characteristics and classification of the risk supporting the reason for the risk being individually risk rated, including any modifications to existing approved forms to be used on the risk. The insurer must maintain these records for a period of at least 5 years after the effective date of the policy.

(b) Individual risk rates and modifications to existing approved forms are not subject to this part or part II, except for paragraph (a) and ss. 627.402, 627.403, 627.4035, 627.404, 627.405, 627.406, 627.407, 627.4085, 627.409, 627.4132, 627.4133, 627.415, 627.416, 627.417, 627.419, 627.425, 627.426, 627.4265, 627.427, and 627.428, but are subject to all other applicable provisions of this code and rules adopted thereunder.

(c) This subsection does not apply to private passenger motor vehicle insurance.

(4) The establishment of any rate, rating classification, rating plan or schedule, or variation thereof in violation of part IX of chapter 626 is also in violation of this section. In order to enhance the ability of consumers to compare premiums and to increase the accuracy and usefulness of rate-comparison information provided by the office to the public, the office shall develop a proposed standard rating territory plan to be used by all authorized property and casualty insurers for residential property insurance. In adopting the proposed plan, the office may consider geographical characteristics relevant to risk, county lines, major roadways, existing rating territories used by a significant segment of the market, and other relevant factors. Such plan shall be submitted to the President of the Senate and the Speaker of the House of Representatives by January 15, 2006. The plan may not be implemented unless authorized by further act of the Legislature.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the Florida Hurricane Catastrophe Fund, together with reasonable costs of other reinsurance, but may not recoup reinsurance costs that duplicate coverage provided by the Florida Hurricane Catastrophe Fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium and any over-recoupment shall be subtracted from the following year's reimbursement premium.

(6)(a) If an insurer requests an administrative hearing pursuant to s. 120.57 related to a rate filing under this section, the director of the Division of Administrative Hearings shall expedite the hearing and assign an administrative law judge who shall commence the hearing within 30

days after the receipt of the formal request and shall enter a recommended order within 30 days after the hearing or within 30 days after receipt of the hearing transcript by the administrative law judge, whichever is later. Each party shall be allowed 10 days in which to submit written exceptions to the recommended order. The office shall enter a final order within 30 days after the entry of the recommended order. The provisions of this paragraph may be waived upon stipulation of all parties.

(b) Upon entry of a final order, the insurer may request a expedited appellate review pursuant to the Florida Rules of Appellate Procedure. It is the intent of the Legislature that the First District Court of Appeal grant an insurer's request for an expedited appellate review.

(7)(a) The provisions of this subsection apply only with respect to rates for medical malpractice insurance and shall control to the extent of any conflict with other provisions of this section.

(b) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base, and shall not be used to justify a rate or rate change. Any common-law bad faith action identified as such, any portion of a settlement entered as a result of a statutory or common-law action, or any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees which is identified as being related to the bad faith and punitive damages in these judgments and settlements may not be included in the insurer's rate base and may not be utilized to justify a rate or rate change.

(c) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, either using loss experience solely for this state or giving greater credibility to this state's loss data after applying actuarially sound methods of assigning credibility to such data.

(d) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.

(e) The insurer must apply a discount or surcharge based on the health care provider's loss experience or shall establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used, and must provide a copy of such schedule or description, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(f) Each medical malpractice insurer must make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.

(8)(a)1. No later than 60 days after the effective date of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature, the office shall calculate a presumed factor that reflects the impact that the changes contained in such legislation will have on rates for medical malpractice insurance and shall issue a notice informing all insurers writing medical malpractice coverage of such presumed factor. In determining the presumed factor, the office shall use generally accepted actuarial techniques and standards provided in this section in determining the expected impact on losses, expenses, and investment income of the insurer. To the extent that the operation of a provision of medical malpractice legislation

enacted during the 2003 Special Session D of the Florida Legislature is stayed pending a constitutional challenge, the impact of that provision shall not be included in the calculation of a presumed factor under this subparagraph.

2. No later than 60 days after the office issues its notice of the presumed rate change factor under subparagraph 1., each insurer writing medical malpractice coverage in this state shall submit to the office a rate filing for medical malpractice insurance, which will take effect no later than January 1, 2004, and apply retroactively to policies issued or renewed on or after the effective date of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature. Except as authorized under paragraph (b), the filing shall reflect an overall rate reduction at least as great as the presumed factor determined under subparagraph 1. With respect to policies issued on or after the effective date of such legislation and prior to the effective date of the rate filing required by this subsection, the office shall order the insurer to make a refund of the amount that was charged in excess of the rate that is approved.

(b) Any insurer or rating organization that contends that the rate provided for in paragraph (a) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques provided in this section in making any filing pursuant to this subsection. The office shall review each such exception and approve or disapprove it prior to use. It shall be the insurer's burden to actuarially justify any deviations from the rates required to be filed under paragraph (a). The insurer making a filing under this paragraph shall include in the filing the expected impact of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature on losses, expenses, and rates.

(c) If any provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is held invalid by a court of competent jurisdiction, the office shall permit an adjustment of all medical malpractice rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.

(d) Rates approved on or before July 1, 2003, for medical malpractice insurance shall remain in effect until the effective date of a new rate filing approved under this subsection.

(e) The calculation and notice by the office of the presumed factor pursuant to paragraph (a) is not an order or rule that is subject to chapter 120. If the office enters into a contract with an independent consultant to assist the office in calculating the presumed factor, such contract shall not be subject to the competitive solicitation requirements of s. 287.057.

(9)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a rate filing:

1. The signing officer and actuary have reviewed the rate filing;

2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading;

Specific Authority

3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and

4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.

(b) A signing officer or actuary knowingly making a false certification under this subsection commits a violation of s. 626.9541(1)(e) and is subject to the penalties under s. 626.9521.

(c) Failure to provide such certification by the officer and actuary shall result in the rate filing being disapproved without prejudice to be refiled.

(d) The commission may adopt rules and forms pursuant to ss. 120.536(1) and 120.54 to administer this subsection.

(10) The burden is on the office to establish that rates are excessive for personal lines residential coverage with a dwelling replacement cost of $1 million or more or for a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more. Upon request of the office, the insurer shall provide to the office such loss and expense information as the office reasonably needs to meet this burden.

(11) Any interest paid pursuant to s. 627.70131(5) may not be included in the insurer's rate base and may not be used to justify a rate or rate change.

627.0629 Residential property insurance; rate filings.--

(1)(a) It is the intent of the Legislature that insurers must provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques shall include, but not be limited to, fixtures or construction techniques which enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques which meet the minimum requirements of the Florida Building Code must be included in the rate filing. All insurance companies must make a rate filing which includes the credits, discounts, or other rate differentials or reductions in deductibles by February 28, 2003. By July 1, 2007, the office shall reevaluate the discounts, credits, other rate differentials, and appropriate reductions in deductibles for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code, based upon actual experience or any other loss relativity studies available to the office. The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings.

(b) By February 1, 2011, the Office of Insurance Regulation, in consultation with the Department of Financial Services and the Department of Community Affairs, shall develop and make publicly available a proposed method for insurers to establish discounts, credits, or other rate differentials for hurricane mitigation measures which directly correlate to the numerical

Specific Authority

rating assigned to a structure pursuant to the uniform home grading scale adopted by the Financial Services Commission pursuant to s. 215.55865, including any proposed changes to the uniform home grading scale. By October 1, 2011, the commission shall adopt rules requiring insurers to make rate filings for residential property insurance which revise insurers' discounts, credits, or other rate differentials for hurricane mitigation measures so that such rate differentials correlate directly to the uniform home grading scale. The rules may include such changes to the uniform home grading scale as the commission determines are necessary, and may specify the minimum required discounts, credits, or other rate differentials. Such rate differentials must be consistent with generally accepted actuarial principles and wind-loss mitigation studies. The rules shall allow a period of at least 2 years after the effective date of the revised mitigation discounts, credits, or other rate differentials for a property owner to obtain an inspection or otherwise qualify for the revised credit, during which time the insurer shall continue to apply the mitigation credit that was applied immediately prior to the effective date of the revised credit.

(2)(a) A rate filing for residential property insurance made on or before the implementation of paragraph (b) may include rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses the risk of wind damage; however, such a rate filing must also provide for variations from such rate factors on an individual basis based on an inspection of a particular structure by a licensed home inspector, which inspection may be at the cost of the insured.

(b) A rate filing for residential property insurance made more than 150 days after approval by the office of a building code rating factor plan submitted by a statewide rating organization shall include positive and negative rate factors that reflect the manner in which building code enforcement in a particular jurisdiction addresses risk of wind damage. The rate filing shall include variations from standard rate factors on an individual basis based on inspection of a particular structure by a licensed home inspector. If an inspection is requested by the insured, the insurer may require the insured to pay the reasonable cost of the inspection. This paragraph applies to structures constructed or renovated after the implementation of this paragraph.

(c) The premium notice shall specify the amount by which the rate has been adjusted as a result of this subsection and shall also specify the maximum possible positive and negative adjustments that are approved for use by the insurer under this subsection.

(3) A rate filing made on or after July 1, 1995, for mobile home owner's insurance must include appropriate discounts, credits, or other rate differentials for mobile homes constructed to comply with American Society of Civil Engineers Standard ANSI/ASCE 7-88, adopted by the United States Department of Housing and Urban Development on July 13, 1994, and that also comply with all applicable tie-down requirements provided by state law.

(4) The Legislature finds that separate consideration and notice of hurricane insurance premiums will assist consumers by providing greater assurance that hurricane premiums are lawful and by providing more complete information regarding the components of property insurance premiums. Effective January 1, 1997, a rate filing for residential property insurance shall be separated into two components, rates for hurricane coverage and rates for all other coverages. A premium notice reflecting a rate implemented on the basis of such a filing shall separately indicate the premium for hurricane coverage and the premium for all other coverages.

(5) In order to provide an appropriate transition period, an insurer may, in its sole discretion, implement an approved rate filing for residential property insurance over a period of years. An

Specific Authority

insurer electing to phase in its rate filing must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing.

(6) Any rate filing that is based in whole or part on data from a computer model may not exceed 15 percent unless there is a public hearing.

(7) An insurer may implement appropriate discounts or other rate differentials of up to 10 percent of the annual premium to mobile home owners who provide to the insurer evidence of a current inspection of tie-downs for the mobile home, certifying that the tie-downs have been properly installed and are in good condition.

(8) EVALUATION OF RESIDENTIAL PROPERTY STRUCTURAL SOUNDNESS.--

(a) It is the intent of the Legislature to provide a program whereby homeowners may obtain an evaluation of the wind resistance of their homes with respect to preventing damage from hurricanes, together with a recommendation of reasonable steps that may be taken to upgrade their homes to better withstand hurricane force winds.

(b) To the extent that funds are provided for this purpose in the General Appropriations Act, the Legislature hereby authorizes the establishment of a program to be administered by the Citizens Property Insurance Corporation for homeowners insured in the high-risk account.

(c) The program shall provide grants to homeowners, for the purpose of providing homeowner applicants with funds to conduct an evaluation of the integrity of their homes with respect to withstanding hurricane force winds, recommendations to retrofit the homes to better withstand damage from such winds, and the estimated cost to make the recommended retrofits.

(d) The Department of Community Affairs shall establish by rule standards to govern the quality of the evaluation, the quality of the recommendations for retrofitting, the eligibility of the persons conducting the evaluation, and the selection of applicants under the program. In establishing the rule, the Department of Community Affairs shall consult with the advisory committee to minimize the possibility of fraud or abuse in the evaluation and retrofitting process, and to ensure that funds spent by homeowners acting on the recommendations achieve positive results.

(e) The Citizens Property Insurance Corporation shall identify areas of this state with the greatest wind risk to residential properties and recommend annually to the Department of Community Affairs priority target areas for such evaluations and inclusion with the associated residential construction mitigation program.

(9) A property insurance rate filing that includes any adjustments related to premiums paid to the Florida Hurricane Catastrophe Fund must include a complete calculation of the insurer's catastrophe load, and the information in the filing may not be limited solely to recovery of moneys paid to the fund.

627.0645 Annual filings.--

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

Specific Authority

(b) Commercial property and casualty insurance as defined in s. 627.0625(1) other than commercial multiple line and commercial motor vehicle,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

(2)(a) Deviations filed by an insurer to any rating organization's base rate filing are not subject to this section.

(b) The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(3) The filing requirements of this section shall be satisfied by one of the following methods:

(a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive, inadequate, or unfairly discriminatory pursuant to the applicable rating laws and pursuant to rules of the commission.

(b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062.

(4) An insurer may satisfy the annual filing requirements of this section by being a member or subscriber of a licensed rating organization which complies with the requirements of this section.

(5) If an insurer does not employ or otherwise retain the services of an actuary, the insurer's rate filing or certification that rates are actuarially sound shall be prepared by insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. A rate filing or certification prepared by a consultant must be reviewed and signed by an employee of the insurer who is authorized to approve rate filings.

(6) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.

(7) Nothing in this section limits the office's authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory pursuant to s. 627.062.

(8) As used in this section, the term "actuary" means an individual who is a member of the Casualty Actuarial Society.

(9) If an insurer fails to meet the filing requirements of this section and does not submit the filing within 60 days after the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for the line of insurance for which the required filing was not made until such time as the office determines that the required filing is properly submitted.

Specific Authority

627.711 Notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection form.--

(1) Using a form prescribed by the Office of Insurance Regulation, the insurer shall clearly notify the applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability and the range of each premium discount, credit, other rate differential, or reduction in deductibles, and combinations of discounts, credits, rate differentials, or reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed or implemented. The prescribed form shall describe generally what actions the policyholders may be able to take to reduce their windstorm premium. The prescribed form and a list of such ranges approved by the office for each insurer licensed in the state and providing such discounts, credits, other rate differentials, or reductions in deductibles for properties described in this subsection shall be available for electronic viewing and download from the Department of Financial Services' or the Office of Insurance Regulation's Internet website. The Financial Services Commission may adopt rules to implement this subsection.

(2) By July 1, 2007, the Financial Services Commission shall develop by rule a uniform mitigation verification inspection form that shall be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance. In developing the form, the commission shall seek input from insurance, construction, and building code representatives. Further, the commission shall provide guidance as to the length of time the inspection results are valid. An insurer shall accept as valid a uniform mitigation verification form certified by the Department of Financial Services or signed by:

(a) A hurricane mitigation inspector employed by an approved My Safe Florida Home wind certification entity;

(b) A building code inspector certified under s. 468.607;

(c) A general or residential contractor licensed under s. 489.111;

(d) A professional engineer licensed under s. 471.015 who has passed the appropriate equivalency test of the Building Code Training Program as required by s. 553.841; or

(e) A professional architect licensed under s. 481.213.

M E M O R A N D U M

DATE: November 3, 2009

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Steven H. Parton, General Counsel

FROM: Dennis Threadgill
Bob Prentiss

SUBJECT: Cabinet Agenda for November 17, 2009
Request for Approval to Publish Amendments to
Rule 69O-236.001; Annual Report Card
Assmt. # 44299

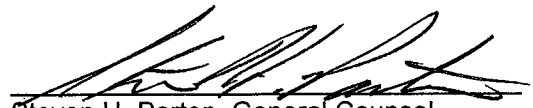
The Office of Insurance Regulation and the Office of the Consumer Advocate request that these proposed rule amendments be presented to the Cabinet aides on or before November 12, 2009, and to the Financial Services Commission on November 17, 2009, with a request to approve for publication the proposed rules.

To adopt the annual report card to be used by the Office of the Consumer Advocate, as required by Section 627.0613.

Section 627.0613, F.S., provide rulemaking authority and laws implemented for this rule.

Bob Prentiss is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:



Steven H. Parton, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-236.001 Purpose.

The purpose of the rules is to establish procedures to be used by the Office of the Insurance Consumer Advocate in preparing an annual report card for each personal residential property insurer. The rules do not apply to eligible surplus lines insurers or to insurers that do not write any homeowner's, mobile home owner's, dwelling, tenant's, condominium unit owner's, cooperative unit owner's, or similar personal residential property insurance.

Rulemaking Authority 624.308(1), 627.0613(4) FS. Law Implemented 627.0613(4) FS. History–New _____.

690-236.002 Definitions.

(1) "Complaint" means any written communication that expresses dissatisfaction with a specific personal residential property insurer subject to regulation under Florida's insurance laws. An oral communication which is subsequently converted to a written form meets the definition of a complaint for this purpose.

(2) "Division" means the Division of Consumer Services of the Department of Financial Services.

(3) "Experience period" means the latest five calendar years for the purpose of evaluating complaints and the latest five calendar-accident years for the purpose of evaluating time to pay claims.

(4) "Personal residential property insurer" means an insurer that writes personal residential property insurance such as homeowner's, mobile home owner's, dwelling, tenant's, condominium unit owner's, cooperative unit owner's and similar policies and includes an insurer that, in addition to writing personal residential property insurance policies, also writes commercial residential property insurance policies such as condominium association, cooperative association, apartment building and similar policies.

(5) "Qualifying premium" means a personal residential property insurer's total direct written personal and commercial residential property insurance premiums in this state during the experience period excluding the latest year's premium.

Rulemaking Authority 624.308(1), 627.0613(4) FS. Law Implemented 627.0613(4) FS. History–New _____.

690-236.003 Methodology.

(1) The Division currently divides complaints into numerous specific categories. For the purposes of the Insurer Report Card, complaints received by the Division will be grouped as follows: premium related complaints, loss related complaints and valid complaints. Premium related complaints and loss related complaints are mutually exclusive. Valid complaints are a subset of premium related complaints and loss related complaints.

(2) A complaint is not valid if the disposition is categorized by the Division as one of the following:

(a) Agent Position Upheld;

(b) Company Position Upheld;

(c) Complaint Withdrawn;

(d) Contractual Provision;

(e) Coverage Explained;

(f) F-map Information;

(g) Information Provided;

(h) Insufficient Information;

(i) Missing;

(j) No Jurisdiction;

(k) Not Eligible for Mediation;

(l) Pamphlet Request;

(m) Referred To FIGA;

(n) Referred To Proper Agency;

(o) Sent To Proper Agency.

(3) For the first annual Insurer Report Card, each insurer will receive a separate grade for each year in the experience period and for the 5-year experience period overall. The grade will be based on a percentage rank in accordance with subsections (4) and (5). The percentage rank will be determined for each insurer for each year in the experience period and for the 5-year experience period overall based on the following four factors:

(a) The insurer's market share of all premium related complaints (valid and invalid) compared to its market share of in-force policies on a calendar year basis;

(b) The insurer's market share of all loss related complaints (valid and invalid) compared to its share of the prior year's in-force policies on a calendar year basis;

(c) The insurer's market share of valid complaints compared to its share of the average of the latest year's and the prior year's in-force policies on a calendar year basis; and

(d) The insurer's average number of months to pay claims compared to the median number of months to pay claims of all insurers on a calendar-accident year basis.

(4) Based on the insurer's percentage rank, each insurer will receive a letter grade in accordance with the following:

(a) A grade of A if the insurer's percentage rank is in the top 15%;

(b) A grade of B if the insurer's percentage rank is in the next 20%;

(c) A grade of C if the insurer's percentage rank is in the next 30%;

(d) A grade of D if the insurer's percentage rank is in the next 20%; and

(e) A grade of E if the insurer's percentage rank is in the last 15%.

(5) Each insurer is assigned an overall grade based upon a weighted average determined as follows:

(a) 10% weight to premium related complaints grade;

(b) 10% weight to loss related complaints grade;

(c) 30% weight to valid complaints grade; and

(d) 50% weight to average number of months to pay claims grade.

(6) To provide appropriate incentives for the second and subsequent years' annual Insurer Report Cards, each insurer will be graded on absolute scales developed from the first annual Insurer Report Card experience period. Absolute grading scales will reflect higher expected complaint ratios in hurricane years.

(7) The Office of the Insurance Consumer Advocate will issue an annual report card on a form that provides the name of each insurer followed by a letter grade for:

(a) Overall score;

(b) Premium related complaint score;

(c) Loss related complaint score;

(d) Valid complaint score; and

(e) Score for time to pay claims.

(8) The form entitled "Annual Report Card of the Insurance Consumer Advocate of Residential Property Insurers" is incorporated herein and adopted.

Rulemaking Authority 624.308(1), 627.0613(4) FS. Law Implemented 627.0613(4) FS. History–New _____.

69O-236.004 Limitations and exclusions.

(1) Complaints are classified as loss related, premium related and valid based upon an objective evaluation of the reason and disposition descriptions given to each complaint. Complaints will be evaluated based on the reason and disposition descriptions in the complaint files as of April 1 of the year following the experience period that is being graded.

(2) All complaints for which the complete insurer name is missing from the complaint file are excluded.

(3) Open complaint files or complaints for which the complaint disposition description is missing are treated as invalid complaints, except for complaints for which the reason description is judged to describe a valid complaint.

(4) Missing complaint reason descriptions are treated as premium related complaints.

(5) All flood complaints are excluded.

(6) Claims are assumed to be paid on average in the middle of the calendar year in which they close.

(7) For calendar-accident years in which a company had fewer than 50 paid claims as of the end of the latest calendar year, such claims are assumed to have been paid in the industry average number of months.

(8) Insurers with less than $30 million in qualifying premium are graded on each of the four factors but are given an overall grade of "I" for "insufficient complaint history" due to a lack of actuarial credibility.

(9) Insurers with less than 5 years of experience are only graded for those years for which they had experience.

(10) Insurers with less than $100,000 in qualifying premium in the latest calendar year will not be graded.

Rulemaking Authority 624.308(1), 627.0613(4) FS. Law Implemented 627.0613(4) FS. History–New _____.

690-236.005 Data sources. The insurer report card will be based on data obtained from the following sources:

(1) Complaint data from the Division of Consumer Services, Florida Department of Financial Services;

(2) Paid claim data from the Statutory Annual Statements, Schedule P, Part 5A, Section 1, filed by insurers with the Office of Insurance Regulation; and

(3) In-force policy and direct written premium data from the Quarterly Summary Reports (QSR) of the Florida Office of Insurance Regulation.

Rulemaking Authority 624.308(1), 627.0613(4) FS. Law Implemented 627.0613(4) FS. History–New____.

Date

ANNUAL REPORT CARD of the INSURANCE CONSUMER ADVOCATE

FOR RESIDENTIAL PROPERTY INSURERS

Company Name	Grades				
	Premium Related Complaints	Loss Related Complaints	Valid Complaints	Time To Pay Claims	Overall

(11-2009)
Rule 69O-236.001

627.0613 Consumer advocate.--The Chief Financial Officer must appoint a consumer advocate who must represent the general public of the state before the department and the office. The consumer advocate must report directly to the Chief Financial Officer, but is not otherwise under the authority of the department or of any employee of the department. The consumer advocate has such powers as are necessary to carry out the duties of the office of consumer advocate, including, but not limited to, the powers to:

(1) Recommend to the department or office, by petition, the commencement of any proceeding or action; appear in any proceeding or action before the department or office; or appear in any proceeding before the Division of Administrative Hearings relating to subject matter under the jurisdiction of the department or office.

(2) Have access to and use of all files, records, and data of the department or office.

(3) Examine rate and form filings submitted to the office, hire consultants as necessary to aid in the review process, and recommend to the department or office any position deemed by the consumer advocate to be in the public interest.

(4) Prepare an annual report card for each authorized personal residential property insurer, on a form and using a letter-grade scale developed by the commission by rule, which grades each insurer based on the following factors:

(a) The number and nature of consumer complaints, as a market share ratio, received by the department against the insurer.

(b) The disposition of all complaints received by the department.

(c) The average length of time for payment of claims by the insurer.

(d) Any other factors the commission identifies as assisting policyholders in making informed choices about homeowner's insurance.

(5) Prepare an annual budget for presentation to the Legislature by the department, which budget must be adequate to carry out the duties of the office of consumer advocate.

State of Florida
Department of Financial Services
FINANCIAL SERVICES COMMISSION
OFFICE OF INSURANCE REGULATION
DFS OIR RFP 09/10- 08
For
ACTUARIAL CONSULTING SERVICES OF THE NATIONAL COUNCIL ON COMPENSATION INSURANCE

ISSUING OFFICER:
Fran Spivey, Purchasing Director
Florida Department of Financial Services,
Purchasing Services
200 E Gaines St Room B24
Tallahassee, Florida 32399-0317
Telephone: 850/413-2065 / Fax: 850/487-2389
Email: fran.spivey@myfloridacfo.com

SECTION 1: INTRODUCTORY SECTION

Section 627.285, Florida Statutes, requires that the Financial Services Commission ("Commission") contract for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance in Florida. The National Council on Compensation Insurance ("NCCI") is responsible for collecting statistical information and making workers' compensation rate filings, on behalf of Florida's insurers. The statute requires a final report no later than February 1, 2010 and requires full cooperation on the part of NCCI. The costs of the independent actuarial peer review are paid from the Worker's Compensation Administration Trust Fund. The technical specifications and Scope of Services are provided in Attachment C. RFP Section 3 and the Forms and Attachments, serve as Special Conditions to supplement or supersede the General Contract Conditions contained in PUR 1000.

1.1 Purpose

The Commission, through the Office of Insurance Regulation, ("Office"), requests written proposals from qualified firms, ("Vendors"), to provide actuarial consulting services to conduct an independent actuarial peer review and analysis of the ratemaking processes of NCCI, pursuant to the requirements of Section 627.285, Florida Statutes.

1.2 Purchasing Agent

The Purchasing Agent is the sole point of contact from the date of release of this RFP until selection of a successful respondent. All procedural questions and requests for clarification of this solicitation shall be submitted to:

Department of Financial Services,
Office of Insurance Regulation
Attn: Fran Spivey, Purchasing Services
200 E. Gaines Street, Larson Building
Tallahassee, FL 32399-0317
Phone: 850/413-2065
Fax: 850/487-2389
Email: fran.spivey@myfloridacfo.com

Responses to questions will be posted on the Vendor Bid System (VBS) website, at http://fcn.state.fl.us/owa_vbs/owa/vbs_www.main_menu (modifies PUR 1001 ¶5).

1.3 Purchasing Instructions and General Conditions

PUR Forms 1001, General Instructions to Respondents, and PUR 1000, General Conditions, which (except as modified by these Special Conditions) are incorporated and attached or available online at
http://dms.myflorida.com/business_operations/state_purchasing/documents_forms_references_resources/purchasing_forms

1.4 TIMETABLE

The following schedule will be strictly adhered to in all actions relative to this solicitation:

Action	Date
Release of solicitation	September 9, 2009
Last day for written inquiries, COB.	September 21, 2009
Written responses to enquiries posted, on or about.	September 25, 2009
Response Submissions due by 3:00 P.M. ET.	October 9, 2009
Estimated Posting of Intent to Award, on or about.	October 20, 2009

The Office reserves the right to make adjustments to this schedule and will notify participants in the solicitation. Adjustments to the schedule will be announced to all Vendors who have expressed interest by participating in the events listed in the table above.

1.5 Bidder's Conference. There will not be a Bidder's or Vendor's conference.

1.6 Definitions.

Solicitation Definitions:
1.6.1 "Actuary": An actuary who is a member of the Casualty Actuarial Society.
1.6.2 "Business days" include only Monday through Friday, inclusive, except for holidays declared and observed by the state government of Florida.
1.6.3 "Business hours" means 9AM to 5 PM on all business days.
1.6.4 "Calendar days" count all days, including weekends and holidays.
1.6.5 "Contract" Unless indicated otherwise, "contract" refers to the contract that will be awarded to the successful Vendor under this RFP.
1.6.6 "Vendor" or "Provider" refers, unless indicated otherwise, to a business entity to which a contract has been awarded by the Office in accordance with a proposal submitted by that entity in response to this RFP.
1.6.7 "Desirable Conditions" means, the use of the words "should" or "may" in this solicitation indicate desirable attributes or conditions, but are permissive in nature. Deviation from, or omission of, such a desirable feature, will not in itself cause rejection of a proposal.
1.6.8 "Mandatory Requirements", means that the Office has established certain requirements with respect to proposals to be submitted by Vendors. The use of shall, must, or will (except to indicate simple futurity) in this solicitation indicates compliance is mandatory. Failure to meet mandatory requirements will cause rejection of the proposal or termination of a contract.
1.6.9 "Minor Irregularity" , used in the context of this solicitation and contract, indicates a variation from the proposal terms and conditions which does not affect the price of the Proposal, or give the Vendor an advantage or benefit not enjoyed by other Vendors, or does not adversely impact the interests of the Office.
1.6.10 "Office" means the Office of Insurance Regulation. This may also be referred to as Buyer.
1.6.11 "RFP" refers to this Request for Proposals and includes attachments to this Request for Proposals unless stated otherwise.
1.6.12 "Vendor" and "Respondent" both mean the business or entity that submits materials to the Office in accordance with these Instructions, or other business or entity responding to this solicitation. This may also be referred to as Provider. The solicitation response may be referred to as proposal or response.
1.6.13 "Vendor Bid System" and "VBS" refers to the State of Florida internet-based vendor information system at http://fcn.state.fl.us/owa_vbs/owa/vbs_www.main_menu.

1.7 Solicitation Terms and Conditions.

The provisions of this solicitation, including the RFP and all its attachments, shall be read as a whole. In case of conflict between provisions, provisions shall have the order of precedence listed below, where the top listed item has the highest precedence:

- The Contract (Attachment D to the RFP)
- Statement of Work (Attachment C to this RFP)
- RFP Sections 1, 2 and 3
- Other Attachments to the RFP
- Instructions to Respondents (PUR 1001),
- General Conditions (PUR 1000)

If there are any perceived inconsistencies among any of the provisions of the RFP and its attachments, Vendors shall bring these inconsistencies to the attention of the Office prior to the submission of the proposal. To report inconsistencies, Vendors must submit a formal question prior to the submission of proposal. The Contract, Attachment D, after execution by the parties, will take precedence over the RFP document.

The Office objects to and shall not consider any terms or conditions submitted by a respondent, including any appearing in documents attached as part of a respondent's response, which are inconsistent with or contrary to the requirements, terms, or conditions of this RFP. In submitting its response, a respondent agrees that any such inconsistent or contrary terms or conditions, whether submitted intentionally or inadvertently, shall have no force or effect, and that the Office shall not be held to have acquiesced to such term or condition. Failure to comply with terms and conditions of the RFP, including those specifying information that must be submitted with a response, shall be grounds for rejecting a response.

SECTION 2: TECHNICAL SPECIFICATIONS AND STATEMENT OF WORK

2.1 SCOPE

Section 627.285, Florida Statutes, requires the Commission, to contract for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance. The analysis of ratemaking should specifically include an analysis of the processes employed in evaluating and pricing the affect of legislation or new law. The National Council on Compensation Insurance is responsible for collecting statistical information and making workers' compensation rate filings on behalf of Florida's insurers. A final report is due to the Commission, President of the Senate and Speaker of the House by February 1, 2010.

The following functionality will serve as the high level deliverables and their due dates:

A. Conduct peer review and analysis, in accordance with accepted actuarial practice and any standards for such analysis established by the Casualty Actuarial Society and/or the American Academy of Actuaries.
B. Status briefings, which may be conducted by teleconference, as requested by the Office.

C. Draft a report which outlines objectives and approach of the project; documents the data used, materials reviewed, assumptions and methodologies employed during the project including reference to any Actuarial Standards of Practice; and details of findings and recommendations, if any.
D. Final Report, consistent with format and content described above, to the Office of Insurance Regulation, no later than January 11, 2010.
E. Expert Witness Testimony during any 2010 Session of the Florida Legislature as required. Such services will be provided pursuant to a separate contract to be entered into between the Office and the Vendor, in the event such services are required.

The Office will include a process in the contract for testing, inspection and acceptance of deliverables.

SECTION 3: SPECIAL CONDITIONS

3.1 PROPOSAL CONTENTS

The Technical Proposal is to be divided into the sections described below. The Office will expect all technical proposals to be in this format, and **failure of the Vendor to follow this outline may result in the proposal being found non-responsive.**

RESPONSES MUST ADDRESS EACH OF THE FOLLOWING REQUIREMENTS. Additional information that is thought to be relevant, but does not fit into the enumerated categories, should be provided as an appendix to the proposal.

All information relating to cost must be included only in the Cost Proposal. **Any reference to cost in the Technical Proposal may result in that proposal being found non-responsive.**

3.1.1- Executive Summary – Tab 1

The Vendor must provide an Executive Summary to be written in non-technical language that summarizes the Vendor's overall capabilities and approaches for accomplishing the services specified herein. The Executive Summary shall include a brief statement of the Vendor's understanding of the services required by the RFP. The Vendor is encouraged to limit the summary to no more than three (3) pages.

3.1.2 Management Plan – Tab 2

The Vendor must provide a management plan that describes administration, management, experience, key personnel and financial information.

a. Administration and Management
Vendor must include a description of the organizational structure established and the methodology to be used to control costs, service reliability and to maintain schedules; as well as the means of coordination and communication between the organization and the Office.

b. Experience
Vendor must provide documentation of previous experience in conducting services similar to the requirements of this RFP; specify any experience in peer reviews of ratemaking methodologies and practices. Experience should be reflective of the Vendor's ability to perform the services requested in this RFP.

c. Identification of Key Personnel
Vendor must provide the names and titles of key management personnel as well as provide documentation of certification of membership of the Casualty Actuarial Society for members of the Vendor's team. A resume for each individual that will be engaged in this project is required. A description of the functions and responsibilities of each key person relative to the task to be performed is also required.

Vendor must include a listing of all persons who will work on this project along with their experience and qualifications. Any work for the NCCI by any person who will be involved in this project over the past five (5) years should be clearly noted and explained. Any potential conflict of interest arising out of current or past work performed for NCCI should be clearly noted and explained.

In addition, identify by name and address, any services provided by any person that may perform work under this project whether or not they are a full-time regular salaried employee of your firm, or sub-Vendors as defined in Section 4.4. Include their qualifications, education and experience. Specify whether each person described in response to this section fulfills a professional or technical capacity.

3.1.3 Work Plan / Technical Approach – Tab 3

The Vendor must provide a detailed work plan, which explains the approach that the Vendor intends to pursue to deliver the services required in this RFP.

The work plan must specify all necessary major tasks to be performed, any tasks, which are dependent upon the completion of other tasks, and completion dates for all major tasks identified in the work plan. The work plan must also specify accountable parties for each major task. The work plan must also specify the approximate number of hours to be spent on this project, by each level of personnel, and the nature of work to be performed by such personnel. For example: Any work to be performed by a Fellow of the CAS versus an Associate of the CAS must be noted.

The work plan must also provide an outline of the expected component parts for the final report identifying key areas to be addressed in the report.

The Vendor must explain the approach, capabilities, and the means to be used in accomplishing the requirements of the RFP. Any specific techniques to be used should also be identified.

Minor deviations from non-mandatory specifications of this RFP are permitted, but reasons for changes should be fully explained and justified. If more than one approach or alternative is proposed, provide an explanation on why an alternative approach(es) is offered.

3.1.4 Forms - Tab 4

The Vendor shall complete the following forms and submit as part of the Proposal Package as described below. Any Proposal in which these forms are not used or are improperly executed may be considered non-responsive and the proposal may be subject to rejection.

The below forms will need to be completed and executed by Vendor and submitted as part of your Technical Response.

a. **Price Proposal/Certification and Agreement (Attachment A)** By signing the Price Proposal (Attachment A), the Vendor agrees to each of the Office's requirements as described in **Attachment C, Scope of Services,** of this RFP to qualify for selection under this RFP.
b. **Identical Tie Response Preference Certification Form (Attachment B):** Whenever identical solicitation Responses are received, preference shall be given to the Response certifying in accordance with Section 60A-1.011, Florida Administrative Code and Florida Statutes.
c. **Disclosure of Independence and Relationship (see Section 3.1.5 below – this must be provided in writing by the Vendor to the Office).**

3.1.5 Disclosure of Independence and Relationship

Vendors must provide certification in writing to the Office that no relationship exists between the Vendor, NCCI, and any other person or organization that would constitute a conflict of interest with respect to the contract that would be entered into as a result of this RFP. If the contract is awarded to an entity that is regulated by the Office with respect to services requested in this RFP, such entity must divest itself of its status as a regulated entity. The Commission will not execute a contract with an entity if full compliance with Chapter 112, Part III, Florida Statutes, cannot be assured.

3.1.6. Separately sealed Price Proposal

The proposal must contain a signed separately sealed **Price Proposal (Attachment A),**

3.1.7 MANDATORY DOCUMENTS AND REQUIREMENTS

All Proposals received will be screened for compliance with these minimum qualifications. Any Proposal that does not demonstrate satisfaction of the minimum qualifications will not receive any further consideration. The mandatory minimum qualifications are:

1. The Proposal must be delivered timely.
2. The Proposal must include an original. Also include 5 paper copies of the Technical proposals offered by the Vendor, as well as __1__ digital copy (compact disks) of each proposal. {modifies PUR 1001 ¶ 3]
3. The Technical Proposal must include all mandatory requirements and respond to all technical requirements in Section 3, Scope of Work, and including all mandatory forms and attachments.
4. The Technical Proposal must include evidence of Respondent's qualifications(see Sec. 3.1.2).
5. The one (1) separately sealed Price Proposal, must include the price proposed and a signature by an authorized representative of the Vendor.
6. Receipt of all required proposal contents, including all mandatory forms and appendices:
   TECHNICAL PROPOSAL PACKAGE INCLUDES:
   Response to the requirements of this RFP
   Identical Tie Response Certification Form (Attachment B)

COST PROPOSAL PACKAGE INCLUDES:
Certification and Agreement (Attachment A)

7. Signed statement that Respondent(s) has/have no conflict of interest (see Section 3.1.5)

3.2 SUBMISSION INSTRUCTIONS

3.2.1 Proposals shall be prepared simply and economically. The Office is not liable for any cost incurred by a Vendor in responding to this solicitation. The Vendor is required to examine carefully the contents of the solicitation and be thoroughly informed regarding all of its requirements.

3.2.2 Format and Copies
• In responding to the requirements in each section, structure your response to match the order of any sub-headings in the section as presented in the RFP, to facilitate the comparison of your offer to the agency's requirements.

•Sealed Proposals must be received in the **Department of Financial Services, Purchasing Services, Attn: Fran Spivey at the 200 East Gaines Street, Larson Bldg., Tallahassee, FL 32399-0317** by the deadline listed in the Timetable in Section 1.4. All Proposals received by the deadline will be opened in the Purchasing Office at that time. Mark the Proposal package clearly on the outside with: RESPONSE NUMBER, DATE AND TIME OF PROPOSAL OPENING. Provide one (1) original and five (5) copies of the Proposal as well as one (1) digital copy (compact disk).

•The "original" proposal will contain the originals of any documents required to be signed as part of the proposal submission (e.g., cover letter). The original proposal as submitted should bear the following printed information on both its outside front cover, and on its spine:

[Vendors exact legal name, in which name contract would be awarded]
Proposal regarding RFP # ____
ORIGINAL
Binder __ of __

•Include with the copies of the proposal photocopies of signed documents. Bind each copy in a 3-ring binder(s) ("Binder") just as the original, with a complete and exact duplicate of the original. Each copy of the proposal should bear the following printed information on both its outside front cover, and on its spine:

[Vendors name in which name contract would be awarded]
Proposal regarding RFP # ____
Copy # ___, Binder __ of __

3.2.3 No negotiations, decisions, or actions shall be initiated or executed by the Vendor as a result of any discussions with any Office employees. Only communications which are in writing from the Office may be considered as duly authorized communications on behalf of the Office. During

selection the respondent, its agents and employees will not engage in any written or verbal communication with any Office employees whether or not such individual is assisting in the selection of the respondent, regarding the merits of the respondent or whether the Office should retain or select the respondent. The respondent will not engage in any lobbying efforts or other attempts to influence the Office, the evaluation team, in an effort to be selected. The selection period shall begin according to the Timetable in Section 1.4.

3.3 EVALUATION PROCESS

3.3.1 Evaluation Team:
An evaluation team consisting of at least three members, appointed in writing by the Office, will evaluate the proposals. Each member will evaluate the technical proposal independently of the others.

3.3.2 Determination of Conformance
Responses must satisfy certain mandatory minimum requirements in order to proceed into the detailed evaluation phase. All Responses will be reviewed for compliance with these mandatory minimum requirements. Responses that meet these requirements will be accepted into a detailed evaluation phase. WARNING: Responses that fail to meet these mandatory minimum requirements will be rejected and considered no further in the evaluation process.

3.3.3 Technical Proposal
Each team member will evaluate their copy of the proposal independent of the others and provide a score on each section of the Technical proposal, based on the evaluation criteria.

3.3.4 Price Proposal
When the price proposals are opened, the Purchasing Officer will open the cost proposals and they will be evaluated separately. This information will need to be completed on the Cost Proposal Sheet Form 3. The Office seeks to employ the most qualified Vendor within fiscal constraints. Absolute cost will not be the sole factor in the selection process.
Formula: (Lowest Cost /Respondent's Cost) x Cost Points = Respondents Total Cost Points.

3.3.5 Evaluation Criteria
The total value of points possible equals 110. Proposals will be evaluated on the following criteria that are not necessarily listed in order of relative importance. Items a through c should be addressed in the Vendor's response to sections 3.1 through 3.3 of this RFP.

a) Vendor's Qualifications. This criterion includes the ability of the Vendor to meet the terms of the RFP as well as the quality, relevancy and recent nature of similar projects provided to clients by the Vendor. The criterion in this section also includes an evaluation of a Vendor's expertise and experience as an organization to deliver services required by the contract. 30 points

Relevancy of Similar Projects	15 points
Recent Nature of Similar Projects	5 points

Relevant Technical Resources 10 points

b) Professional Personnel. This refers to the education and expertise of the professional and technical personnel who would be assigned to perform services required by the contract. Consideration of the amount of time to be devoted to the project by the various individuals will be used in awarding points in this area. 30 points

Education of Professional Staff 15 points

Experience/Expertise of Professional Staff 15 points

c) Work Plan. Emphasis here is on the ability to provide the services desired as outlined in Attachment A, Scope of Services/Statement of Work and as otherwise described in this RFP. Of equal importance is whether the technical approach is completely responsive to all written specifications and requirements contained in this RFP, and if it meets the RFP objectives. 30 points

d) Cost. This information will need to be completed on the Cost Proposal Sheet, Attachment A. The Office seeks to employ the most qualified Vendor within fiscal constraints. Absolute cost will not be the sole factor in the selection process. Formula: (Lowest Cost /Respondent's Cost) x Cost Points = Respondents Total Cost Points. 20 points

3.3.6 Reservations

The Office reserves the right to reject any and / or all Proposals, or to waive minor discrepancies if it is in the Office's best interest to do so. The Office may, by written notice, revise and amend the solicitation before the due date for the Proposal.

3.3.7 Contract

The Office will provide a contract for signature, substantially in the form attached as Attachment "D", between the Office and successful Vendor that incorporates this solicitation and the vendor's response as soon as possible after the posting of the notice of award on the Vendor Bid System (VBS) website, at http://fcn.state.fl.us/owa_vbs/owa/vbs_www.main_menu.

After selection of the Vendor, the Request for Proposals (including addenda thereto, if any), the proposal of the Vendor, the executed Agreement will constitute the entire agreement of the parties and will supersede any prior representations, commitments, conditions, or agreements between the parties. In the event of conflict among the terms and conditions of the various documents, the Agreement shall prevail over the Request for Proposals. The term "proposal" includes both the Technical and Price Proposals submitted in response hereto.

The Contract shall be substantially in the form attached as Attachment "D" to the RFP, with only such non-substantive changes therein as shall be necessary to the orderly administration of the program. Modifications as noted in this response to the vendors' questions and any other Addenda to the RFP are incorporated into the RFP. The Office reserves the right to amend this Request for Proposals by addendum prior to the date for proposal submission. If there are any perceived inconsistencies among any of the provisions of the RFP and its attachments, Vendors shall bring these inconsistencies to the attention of the Office prior to the submission of the proposal.

3.3.8 Nonexclusive Contract
This procurement will not result in an exclusive license to provide the services/products described in this, RFP or the resulting contract. The Office may, without limitation and without recourse by the Vendor, contract with other Vendors, or with internal staff, to provide the same or similar services.

3.4 ADDITIONAL CONTRACT TERMS

3.4.1 Entire Contract; Order of Precedence. The Contract document, the Office's solicitation including attachments and addenda, and Vendor's Proposal and in that order, state all of the rights and responsibilities of, and supersede all prior oral and written communications between, the parties. The Office objects to and shall not consider any terms or conditions submitted by a Vendor or Respondent, including any appearing in documents attached as part of a respondent's response, which are inconsistent with or contrary to the requirements, terms, or conditions of the RFP. In submitting its response, a respondent agrees that any such inconsistent or contrary terms or conditions, whether submitted intentionally or inadvertently, shall have no force or effect.

3.4.2 Term of Contract: The term of the Contract is until **June 20, 2010** and is not subject to renewal.

3.4.3 Contacts: Send Invoice To: Sheila Bludworth . For all other contract-related notices, the Office contract manager is: Sheila Bludworth . All written and verbal approvals referenced in this Contract must be obtained from the parties' contract managers or designees. Notices required to be in writing must be delivered or sent to the intended recipient by hand delivery, certified mail or receipted courier and shall be deemed received on the date received or the date of the certification or receipt.

3.4.4 Acceptance. All of Vendor' Deliverables related to these commodities or services shall be submitted to Office's contract manager for review and approval. The Office's approval and inspection of Vendor's services shall require no longer than five working days from date of delivery of services, and fifteen working days for delivery of documentary deliverables such as reports and procedures. Office reserves the right to reject deliverables as incomplete, inadequate or unacceptable due in whole or in part to Vendor's lack of satisfactory performance under the terms of this contract. Office, at its option, may allow additional time within which Vendor may remedy the objections noted by Office. (modifies PUR 1000 ¶13)

3.4.5 Dispute Resolution. Any dispute concerning performance of the Contract shall be decided by the Customer's designated contract manager, who shall reduce the decision to writing and send a copy to the Vendor at a previously provided address. In the event a party is dissatisfied with the dispute resolution decision, jurisdiction for any dispute arising under the terms of the contract will be in the Courts of the State of Florida, and venue will be in the Second Judicial Circuit, in and for Leon County. Except as otherwise provided by law, the parties agree to be responsible for their own attorney fees incurred in connection with disputes arising under the terms of this contract. (replaces PUR 1000 ¶31)

3.4.6 Subcontracting. All services contracted for are to be performed solely by the Vendor and may not be subcontracted for or assigned without the prior written consent of the Office.

3.4.7 Insurance: During the Contract term, the Contractor at its sole expense shall provide commercial insurance of such a type and with such terms and limits as may be reasonably associated with the Contract. Providing and maintaining adequate insurance coverage is a material obligation of the Contractor. Upon request, the Contractor shall provide certificate of insurance. The limits of coverage under each policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract. All insurance policies shall be through insurers authorized or eligible to write policies in Florida. Workers' compensation and employer's liability insurance covering all employees engaged in any Contract work, in accordance with Chapter 440 of the Florida Statutes.

3.4.8 Public Records. Notwithstanding any provisions to the contrary, public records shall be made available pursuant to the provisions of the Public Records Act. Trade secrets are not solicited or desired, as submissions with Responses. The Office will advise the Vendor if disclosure of any trade secret as defined in Section 812.082, Florida Statutes, where clearly segregated and identified as such in the Response, is sought. If the Office receives a public records request related to the Proposal, the Vendor shall be solely responsible for taking whatever action it deems appropriate to legally protect its claim of exemption from the public records law. Any prospective vendor acknowledges, that the protection afforded by Section 815.45, Florida Statutes, is incomplete, and it is hereby agreed that that no right or remedy for damages arises from any disclosure. (modifies PUR 1000 ¶33 and PUR 1001, ¶19). Vendor shall retain such records for the longer of (3) three years after the expiration of the Contract or (2) the period required by the General Records Schedules maintained by the Florida Department of State (available at: http://dlis.dos.state.fl.us/recordsmgmt/gen_records_schedules.cfm).

3.4.9 Modification of terms. Any terms and conditions that the Vendor provides with or before or after delivery that attempt to modify the Contract or add additional restrictions of usage, license conditions, or requirements have no effect and are not enforceable under the Contract. (modifies PUR 1000 ¶42) Any proposed software license agreement, service level agreement, or any other draft agreement submitted in the proposal shall not contain any provisions, unless such provisions are expressly negated in the proposal, which:
(1) are inconsistent with Florida law,
(2) exclude, prohibit, or negate other contract documents,
(3) subject the State of Florida to the jurisdiction of another state, or
(4) provide that the State will indemnify the Vendor or any other person,

3.4.10 Taxes: The Office is exempted from payment of Florida state sales and use taxes and Federal Excise Taxes on direct purchases of tangible personal property. The State will not pay for any personal property taxes levied on the Vendor or for any taxes levied on employees' wages. The Office will provide its tax exemption certification upon request. The Vendor shall provide the Office its state or federal taxpayer identification number upon request.

3.4.11 Payment. Section 215.422, Florida Statutes, provides that agencies have 5 working days to inspect and approve goods and services, unless Proposal specifications or the purchase order specifies otherwise. The Office is to approve the invoice in the state financial system within 20 days. If payment is not available within 40 days, measured from the latter of the date the invoice is received or the goods or services are received, inspected and approved, a separate interest penalty set by the Chief Financial Officer pursuant to Section 55.03, Florida Statutes, will be due and payable in addition to the invoice amount. To obtain the applicable interest rate, please refer to www.fldfs.com/aadir/interest.htm. Invoices returned to a Vendor due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the State agency with the proper tax payer identification information documentation to be submitted before the prompt payment standards are to be applied. A Vendor Ombudsman, whose duties include acting as an advocate for Vendors who may be experiencing problems in obtaining timely payments(s) from a state agency, may be contacted at (850) 413-5516.

3.4.12 MyFloridaMarketPlace. Unless exempted under Rule 60A-1.030-.032, each vendor doing business with the State of Florida shall submit reports and be assessed a Transaction Fee of one percent (1.0%), on its payments under a Contract, which must be remitted within 40 days after receipt of payment for which such fees are due or the vendor shall pay interest at the rate established under Sec. 55.03(1), Florida Statutes, on the unpaid balance from the expiration of the 40-day period until the fees are remitted.

3.4.13 Electronic Accessibility. When the agency is to develop, procure, maintain, or use electronic and information technology, the Vendor shall ensure that, as to its products and services, the electronic and information technology allows employees and members of the public with disabilities to have access to and use of information and data that is comparable to the access to and use of information and data by employees who are not individuals with disabilities. These require, e.g., screen enlargement and voice output, or have built-in screen reader or, that the products support assistive technology; increase in volume and/or alter the tonal quality or increase the signal-to-noise ratio; if speech input one alternative input mode also; not require fine motor control or simultaneous actions. See 36 CFR Part 1194 based on Section 508 of the Rehabilitation Act Amendments, 29 USC Sec. 794. (see http://www.section508.gov/)

3.4.14 State property disposition: Title to all property furnished by the Office under this Contract shall remain in the Office, and Vendor shall surrender to the Office all property of the Office prior to settlement upon completion, termination, or cancellation. All drafts, final reports, and work papers shall become and remain the Office's property upon receipt and acceptance.

3.4.15 Nonexclusive Contract. This procurement will not result in an exclusive license to provide the services described in this RFP or the resulting contract. The Office may, without limitation and without recourse by the Vendor, contract with other Vendors to provide the same or similar services.

3.4.16 Limitation of Liability. The Office's maximum liability for any damages, regardless of form of action, shall in no event exceed the fees actually paid to Vendor for the relevant products or services giving rise to the liability.

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ATTACHMENT A

Price Proposal/Certification and Agreement

Vendors are to list the pricing inclusive of all costs to prepare and deliver the services identified within this RFP for Actuarial Services relating to a review of the National Council on Compensation Insurance, (NCCI)

****Total Cost for Services described in this RFP: $_____**

****This figure shall be evaluated for scoring. The criteria for cost evaluation shall be based upon the following formula: (Lowest Cost / Respondent's) x Cost Points = Respondents Total Cost Points**

***Hourly Rate for Expert Witness Testimony if Required by the Office or the Florida Legislature $_____**

*As provided for in Attachment C, Scope of Services/Statement of Work, Item II.E. Such services will be provided pursuant to an amendment to this contract to be entered into between the Office and the Vendor, in the event such services are required. This amount will not be evaluated as basis of award.

I certify that this Response is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a Response for the same materials, supplies or equipment, or services and is in all respects fair and without collusion or fraud. I agree to abide by all conditions of this Response and certify that I am authorized to sign this Response for the Vendor and that the Vendor is in compliance with all requirements of the Response, including but not limited to, certification requirements.

VENDOR NAME: _____
(Company)
VENDOR ADDRESS : _____
(City/State/Zip) _____
VENDOR PHONE: _____
VENDOR E-MAIL CONTACT: _____
AUTHORIZED REPRESENTATIVE:
(Printed) _____
AUTHORIZED SIGNATURE: _____
DATE: _____

ATTACHMENT B

Identical Tie Response Certification

Preference shall be given to the vendor, in the event of identical tie Responses, who (check the applicable block) certifies one or more of the following:

_____A. The response is from a certified minority-owned firm or company;

_____B. The response is from a Florida-domiciled entity

_____C . The commodities are manufactured, grown, or produced within this state;

_____D. Foreign manufacturer with a factory in the State employing over 200 employees working in the State.

_____E. Businesses with drug-free workplace programs. Whenever two (2) or more solicitation Responses which are equal with respect to price, quality and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a solicitation Response received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedures for processing tie solicitation Responses will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation and employee assistance programs and the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under solicitation a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees, as a condition of working on the commodities or contractual services that are under contract, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of Chapter 893 or of any controlled substance law of the United States or any State, for a violation occurring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by any employee who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

I certify that this firm complies fully with the above-selected requirements. (If item E above is selected, subsections "1" through "6" have been met.)

Vendor's Name: _____

Authorized Signature: _____

ATTACHMENT C

Technical Specifications/ Scope of Work
SCOPE OF SERVICES / STATEMENT OF WORK
DFS OIR RFP 09/10-08

The Scope of Services / Statement of Work being requested is outlined below. **Responses to this RFP should provide sufficient detail so as to demonstrate a Vendor's ability to perform all services described as well as the overall approach in which the Vendor expects to perform them.**

I. SCOPE OF SERVICES / STATEMENT OF WORK

Section 627.285, Florida Statutes, requires the Financial Services Commission, to contract for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance. The analysis of ratemaking should specifically include an analysis of the processes employed in evaluating and pricing the affect of legislation or new law. The National Council on Compensation Insurance is responsible for collecting statistical information and making workers' compensation rate filings on behalf of Florida's insurers. A final report is due to the Commission, President of the Senate and Speaker of the House by February 1, 2010.

II. DELIVERABLES

A. Status briefings, which may be conducted by teleconference, as requested by the Office.

B. Conduct peer review and analysis, in accordance with accepted actuarial practice and any standards for such analysis established by the Casualty Actuarial Society and/or the American Academy of Actuaries.

C. Draft a report which outlines objectives and approach of the project; documents the data used, materials reviewed, assumptions and methodologies employed during the project including reference to any Actuarial Standards of Practice; and details of findings and recommendations, if any.

D. Final Report, consistent with format and content described above, to the Office of Insurance Regulation, no later than January 11, 2010.

E. Expert Witness Testimony during any 2010 Session of the Florida Legislature as required. Such services will be provided pursuant to a separate contract to be entered into between the Office and the Vendor, in the event such services are required.

A review of the following documents may prove useful in responding to this request:

1. The National Association of Insurance Commissioners (NAIC) Examination of NCCI, completed in December 1991. This is available from the NAIC at www.naic.org.

2. The Final Report on the Implementation of the NCCI Examination issued by the NAIC in December 1994.

3. The State of Oregon Department of Consumer & Business Services Insurance Division Multi-State Examination of the National Council on Compensation Insurance, Inc. Concluded August 2001.
(http://www.cbs.state.or.us/external/ins/docs/examinations/marketconduct/ncci01mc.pdf)

4. Department of Insurance, Final Order in the matter of National Council on Compensation Insurance, DOAH Case Number 01-4828 issued June 12, 2002.
(http://www.doah.state.fl.us/internet/search/docket.cfm

5. Transcripts of the most recent three NCCI Rate Hearings conducted by the former Florida Department of Insurance are available by contacting Reva Dean at Reva.Dean@fldfs.com.

6. The Final Report issued in response to RFP 03/04-06 issued on January 29, 2004 including the NCCI response.

7. The Final Report issued in response to RFP 05/06-13 issued on January 27, 2006 including the NCCI response.

8. The Final Report issued in response to RFP 07/08-06 issued on January 30, 2008 including the NCCI response.

ATTACHMENT D

PROVIDER CONTRACT

THIS CONTRACT ("Contract") is entered into by and between the State of Florida, Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, Florida 32399 (hereinafter referred to as "Office") or its successor, and _____(hereinafter referred to as "Provider"), effective as of the last date signed below.

WITNESSETH THAT:

WHEREAS, the Office has determined that it is in need of certain services as described herein; and

WHEREAS, the Provider, as an independent Vendor of the Office, has the expertise and ability to faithfully perform such services.

NOW THEREFORE, in consideration of the services to be performed and payments to be made, together with the mutual covenants and conditions hereinafter set forth, the parties agree as follows:

1. Services and Deliverables. The Provider agrees to render the services or other units of deliverables as set forth in the Provider's accepted proposal responding to the Office's Request for Proposals (RFP) for services, RFP # 09/10-08 and its Attachments A, B, and C. The Provider's performance shall be subject to all the terms, conditions, and understandings set forth in said RFP and the attachments to the RFP and PUR 1000 and 1001 incorporated by reference into the RFP.

2. Delivery Schedule. The services or other units of deliverables specified in Paragraph 1 above shall be delivered or otherwise rendered on behalf of the Office in accordance with the schedule in the Provider's accepted proposal and consistent with the RFP. The Provider's performance shall be subject to all the terms, conditions, and understandings set forth in said RFP and the attachments to the RFP.

3. Payment.

3(a) Subject to the terms and conditions established by this Contract and the billing procedures established by the Office, the Office agrees to pay the Provider for services rendered, from the Workers' Compensation Administration Trust Fund.

3(b) Vendor Rights. Vendors providing goods and services to an agency should be aware of the following time frames. Upon receipt, an agency has five (5) working days to inspect and approve the goods and services, unless the Proposal specifications, purchase orders or Contract specifies otherwise. An agency has 20 days to deliver a request for payment (voucher) to the Department of Financial Services. The 20 days are measured from the date the invoice is received after the goods or services are received, inspected and approved. The Office is to approve the invoice in the state financial system within 20 days.

If a payment is not available within 40 days, a separate interest penalty, computed at the rate determined by the State of Florida Chief Financial Officer pursuant to Section 215.422, Florida Statutes, will be due and payable, in addition to the invoice amount, to the vendor. To obtain the

applicable interest rate, please refer to http://www.dbf.state.fl.us/interest.html. Invoices returned to a Vendor due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the State agency with the proper tax payer identification information documentation to be submitted before the prompt payment standards are to be applied. Interest penalties of less than one (1) dollar will not be enforced unless the vendor requests payment. Invoices which have to be returned to a vendor because of vendor preparation errors will result in a delay in the payment. The invoice payment requirements do not start until a properly completed invoice is provided to the agency with the proper tax payer identification information documentation to be submitted before the prompt payment standards are to be applied.

A Vendor Ombudsman has been established with the Department of Financial Services. The duties of this individual include acting as an advocate for vendors who may be experiencing problems in obtaining timely payment(s) from a state agency. The Vendor Ombudsman may be reached at (850) 413-5516.

3(c) Taxes. The Office is exempted from payment of Florida state sales and use taxes and Federal Excise Tax. The Provider, however, shall not be exempted from paying Florida state sales and use taxes to the appropriate governmental agencies or for payment by the Provider to suppliers for taxes on materials used to fulfill its contractual obligations with the Office. The Provider shall not use the Office's exemption number in securing such materials. The Provider shall be responsible and liable for the payment of all its FICA/Social Security and other taxes resulting from this Contract.

3(d) Payment Processing. All charges for services rendered or for reimbursement of expenses authorized by the Office in accordance with Paragraph 4 shall be submitted to the Office in sufficient detail for a proper pre-audit and post-audit to be performed. All payments for professional services and authorized expenses will be paid to the Provider only upon the timely and satisfactory completion of all services and other units of deliverable such as reports, findings and drafts, which are required by Paragraphs 1 and 2 above and upon the written acceptance of said services and units of deliverables such as reports, findings and drafts by the Office's designated contract manager. Interim payments may be made by the Office at its discretion under extenuating circumstances if the completion of services and other units of deliverables to date has first been accepted in writing by the Office's contract manager.

3(e) Contingency. If the terms of this Contract extend beyond the current fiscal year, the State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature.

4. Acceptance

The Office reserves the right to reject deliverables as outlined in the Statement of Work as incomplete, inadequate or unacceptable due in whole or in part to Provider's lack of satisfactory performance under the terms of this contract. The Office, at its option, may allow additional time within which Provider may remedy the objections noted by the Office and the Department may, after having given Provider a reasonable opportunity to complete, make adequate or acceptable said deliverables, including but not limited to reports, declare this Contract to be in default. All

status reports must be submitted timely showing tasks or activities worked on, attesting to the level of services provided, hours spent on each task/activity, and upcoming major tasks or activities. Failure to use the appropriate technical requirements as identified in the Scope of Work will result in automatic task rejection and may not be invoiced or paid until correction of the task. Failure to complete the required duties as outlined in the Statement of Work may result in the rejection of the invoice.

5. State property

Title to all property furnished by the Office under this Contract shall remain in the Office, and Provider shall surrender to the Office all property of the Office prior to settlement upon completion, termination, or cancellation. All documentation resulting from the services provided pursuant to this contract shall become the property of the Office.

6. Termination.

a. The Office may, in its sole discretion, terminate the Contract at any time by giving fifteen (15) days written notice to the Provider.

b. All services performed by the Provider prior to the termination date of this Contract shall be professionally serviced to conclusion in accordance with the requirements of the Contract. Should the Provider fail to perform all services under the Contract, the Provider shall be liable to the Office for any fees or expenses that the Office may incur in securing a substitute provider to assume completion of those services.

c. As provided in Section 287.058, Florida Statutes, the Office may terminate the Contract immediately in the event that the Office requests in writing that the Provider allow public access to all documents, papers, letters, or other material subject to the provisions of Chapter 119, Florida Statutes, which are made or received by the Provider in conjunction with the Contract, and the Provider refuses to allow such access. However, nothing herein is intended to expand the scope or applicability of Chapter 119, Florida Statutes, to the Provider. The Provider shall not be required to disclose to the public any proprietary copyrighted trade secrets or other materials protected by law as pursuant to Section 119.07, Florida Statutes.

d. If at any time the Contract is canceled, terminated, or expires, and a contract is subsequently executed with a firm other than the Provider, the Provider has the affirmative obligation to assist in the smooth transition of Contract services to the subsequent Provider. The Provider agrees to provide termination assistance requested by the Office to facilitate the orderly transfer of such services to the Office or its designees. Such termination assistance shall be at no additional charge to the Office if the termination is due to Provider's default.

e. If the Provider defaults in the performance of any covenant or obligation contained in the Contract, including without limitation the minimum requirements contained in the Scope of Work, or in the event of any material breach of any provision of the Contract by the Provider, the Office may, in its sole discretion, provide notice and an opportunity to cure the default rather than exercise the remedy of termination. If the default or breach is not cured within seven (7) business days after written notice is given to the Provider specifying the nature of the alleged default or breach, then the Office, upon giving written notice to the Provider, shall have the right to terminate the Contract effective as of the date of receipt of the default notice.

7. Provided such failure is not the fault of the Office or outside the reasonable control of the Provider, the following events, acts, or omissions, shall include but are not limited to, events of default:

1) Failure to pay any and all entities, individuals, and the like furnishing labor or materials, or failure to make payment to any other entities as required herein in connection with the Contract;

2) Failure to complete and maintain, within the timeframes specified between the Office and the Provider, the applicable system installation, ongoing performance, maintenance, and provision of Services;

3) The commitment of any material breach of this Contract by the Provider, failure to timely deliver a material deliverable, discontinuance of the performance of the work, failure to resume work that has been discontinued within a reasonable time after notice to do so, or abandonment of the Contract;

4) Employment of an unauthorized alien in the performance of the work;

5) One or more of the following circumstances, uncorrected for more than seven (7) business days unless within the specified period, the Provider (including its receiver or trustee in bankruptcy) provides to the Office adequate assurances, reasonably acceptable to the Office, of its continuing ability and willingness to fulfill its obligations under the Contract:

a) entry of an order for relief under Title 11 of the United States Code;

b) the making by the Provider of a general assignment for the benefit of creditors;

c) the appointment of a general receiver or trustee in bankruptcy of the Provider's business or property;

d) an action by the Provider under any state insolvency or similar law for the purpose of its bankruptcy, reorganization, or liquidation;

e) entry of an order revoking the certificate of authority granted to the Provider by the State or other licensing authority;

6) The Provider makes or has made an intentional material misrepresentation or omission in any materials provided to the Office or fails to maintain the required insurance.

8. Liability and Indemnification

In addition to the provisions in PUR 1000 regarding liability, the following provisions apply: no provision in this Contract shall require the Office to hold harmless or indemnify the Provider, insure or assume liability for the Provider's negligence, waive the Office's sovereign immunity under the laws of Florida, or otherwise impose liability on the Office for which it would not otherwise be responsible. Except as otherwise provided by law, the parties agree to be responsible for their own attorney fees incurred in connection with disputes arising under the terms of this contract.

9. Term of Contract: The term of the Contract is from full execution until **June 20, 2010,** and is not subject to renewal.

10. Contract Modification. This Contract may be amended only by a written agreement between both parties subject to the provisions of Chapter 287, Florida Statutes, and applicable Rules of the Florida Administrative Code.

11. Nonexclusive Contract. This procurement will not result in an exclusive license to provide the services described in this RFP or the resulting contract. The Office may, without limitation and without recourse by the Provider, contract with other Providers to provide the same or similar services.

12. Statutory Notices. The Office shall consider the employment by any Provider of unauthorized aliens a violation of Section 274A(e) of the Immigration and Nationality Act. Such violation shall be cause for unilateral cancellation of this Contract. An entity or affiliate who has been placed on the public entity crimes list or the discriminatory Provider list may not submit a Proposal on a contract to provide any goods or services to a public entity, may not be awarded or perform work as a Provider, supplier, subProvider, or consultant under a contract with any public entity, and may not transact business with any public entity pursuant to limitations under Chapter 287, Florida Statutes.

13. Compliance with Federal, State and Local Laws. Provider and all its agents shall comply with all federal, state and local regulations, including, but not limited to, nondiscrimination, wages, social security, worker's compensation, licenses and registration requirements.

14. Miscellaneous.

(a) This Contract, and any referenced or attached addendum embodies the entire agreement of the parties. There are no other provisions, terms, conditions, or obligations. This Contract supersedes all previous oral or written communications, representations or agreements on this subject. Any conflict between this Contract and any referenced or attached addendum the terms and conditions of this Contract shall take precedence and govern.

(b) In all cases, venue shall be in Leon County, Florida.

(c) The laws of the State of Florida and the applicable Rules of the Florida Administrative Code govern this Contract.

(d) The Provider agrees that no funds received by it under this contract will be expended for the purpose of lobbying the Legislature or a state agency pursuant to Section 216.347, Florida Statutes, except that pursuant to the requirements of section 287.058(6), Florida Statutes, during the term of any executed contract between the Provider and the state, the Provider may lobby the executive or legislative branch concerning the scope of services, performance, term, or compensation regarding that contract.

(e) The Provider is an independent Provider, and is not an employee or agent of the Office.

(f) All services contracted for are to be performed solely by the Provider and may not be subcontracted or assigned without the prior written consent of the Office.

(g) The respective obligations of the parties, which by their nature would continue beyond the termination or expiration of this Contract, including without limitation, the obligations

regarding confidentiality, proprietary interests, and limitations of liability shall survive termination, cancellation or expiration of this Contract.

(h) Provider hereby agrees to protect, indemnify, defend and hold harmless the Office from and against any and all costs, claims, demands, damages, losses and liabilities arising from or in any way related to Provider's breach of this contract or the negligent acts or omissions of Provider.

(i) The Office shall not be deemed to assume any liability for the acts, omissions to act or negligence of the Provider, its agents, servants, and employees, nor shall the Provider disclaim its own negligence to the Office or any third party.

(j) If a court of competent jurisdiction deems any term or condition herein void or unenforceable, the other provisions are severable to that void provision, and shall remain in full force and effect.

16. Contract Administration.

(a) The Office contract manager is _____ located at ____ .
(b) The Provider contract manager is _____ located at _____.
(c) All written and verbal approvals referenced in this Contract must be obtained from the parties' contract administrators or designees. Notices required to be in writing must be delivered or sent to the intended recipient by hand delivery, certified mail or receipted courier and shall be deemed received on the date received or the date of the certification or receipt.

IN WITNESS WHEREOF, the Office of Insurance Regulation and _____, by their duly authorized representatives, have signed this Contract.

_____	_____
Provider Representative:	Office of Insurance Regulation
Title:	Chief of Staff or Designee
Date: _____	Date: _____